

ADMINISTRATIVE REGISTER OF KENTUCKY



LEGISLATIVE RESEARCH COMMISSION
Frankfort, Kentucky

VOLUME 40, NUMBER 8
SATURDAY, FEBRUARY 1, 2014

The submission deadline for this edition of the *Administrative Register of Kentucky* was noon, January 15, 2014.

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MEETING NOTICE: ARRS

The **Administrative Regulation Review Subcommittee** is **tentatively** scheduled to meet February 10, 2014 at 1:30 p.m. in room 149 Capitol Annex. See **tentative agenda** on pages 1525-1527 of this Administrative Register.

Part 1 of 2

The **ADMINISTRATIVE REGISTER OF KENTUCKY** is the monthly supplement for the 2013 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

ADMINISTRATIVE REGISTER OF KENTUCKY

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**ADMINISTRATIVE REGULATION REVIEW SUBCOMMITTEE
TENTATIVE AGENDA, FEBRUARY 10, 2014, at 1:30 p.m., Room 149 Capitol Annex**

**GENERAL GOVERNMENT CABINET
Board of Chiropractic Examiners**

Board

- 201 KAR 21:001. Definitions for 201 KAR Chapter 21.
- 201 KAR 21:015. Code of ethical conduct and standards of practice.
- 201 KAR 21:041. Licensing; standards, fees.
- 201 KAR 21:042. Standards, application, and approval of continuing education courses.
- 201 KAR 21:051. Board hearings.
- 201 KAR 21:052. Appeal of denial of license.
- 201 KAR 21:053. Appeal of revocation of probation.
- 201 KAR 21:054. Emergency orders.
- 201 KAR 21:065. Professional advertising; seventy-two (72) hour right of rescission.
- 201 KAR 21:075. Peer review committee procedures and fees.
- 201 KAR 21:085. Preceptorship Program.
- 201 KAR 21:095. Licensure, registration, and standards of persons performing peer review.
- 201 KAR 21:100. Minimum standards for recordkeeping or itemized statements.

Kentucky Real Estate Appraisers Board

Board

- 201 KAR 30:125. Continuing education for appraisers.
- 201 KAR 30:321. Repeal of 201 KAR 30:320.

Board of Licensure for Professional Art Therapists

Board

- 201 KAR 34:020. Fees.
- 201 KAR 34:025. Application; approved programs.
- 201 KAR 34:030. Continuing education requirements.
- 201 KAR 34:040. Code of ethics.

Board of Medical Imaging and Radiation Therapy

Board

- 201 KAR 46:015. Compensation.
- 201 KAR 46:090. Complaint Process and Administrative Hearings.

**JUSTICE AND PUBLIC SAFETY CABINET
Department of Corrections**

Office of the Secretary

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

Department of Juvenile Justice

Child Welfare

- 505 KAR 1:120. Department of Juvenile Justice Policies and Procedures Manual: Health and Safety Services. (Not Amended After Comments)
- 505 KAR 1:130. Department of Juvenile Justice Policies and Procedures: juvenile services in community. (Deferred from January)
- 505 KAR 1:170 & E. Department of Juvenile Justice Policies and Procedures: Prison Rape Elimination Act of 2003 (PREA). ("E" expires 5/15/2014) (Amended After Comments)

**TRANSPORTATION CABINET
Department of Vehicle Regulation**

Motor Vehicle Tax

- 601 KAR 9:085. Procedures for becoming a certified motor vehicle inspector.

**EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Kentucky Board of Education
Department of Education**

Office of Learning Support Services

- 704 KAR 7:151. Repeal of 704 KAR 7:150. (Deferred from December)

**LABOR CABINET
Kentucky Occupational Safety and Health Review Commission**

Commission

- 803 KAR 50:010. Hearings; Procedure, Disposition.

**PUBLIC PROTECTION CABINET
Department of Alcoholic Beverage Control**

Advertising Distilled Spirits and Wine

- 804 KAR 1:110. Distilled spirits and wine tastings.

Licensing

- 804 KAR 4:400. ABC basic application and renewal form incorporated by reference.
- 804 KAR 4:410. Special applications and registration forms incorporated by reference.

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**Kentucky Department of Insurance
Property and Casualty Division**

Motor Vehicle Repairs (No-fault)

806 KAR 39:070. Proof of motor vehicle insurance. (Amended After Comments)

**Department of Housing, Buildings and Construction
Division of Heating, Ventilation and Air Conditioning**

Heating, Ventilation, and Air Conditioning Licensing Requirements

815 KAR 8:050. Continuing education requirements for heating, ventilation, and air conditioning (HVAC) license holders.

Department of Charitable Gaming

Charitable Gaming

- 820 KAR 1:001. Definitions for 820 KAR Chapter 1.
- 820 KAR 1:005. Exempt organizations.
- 820 KAR 1:015. Issuance of annual license for a charitable organization.
- 820 KAR 1:016. Distributor and manufacturer licensees.
- 820 KAR 1:025. Financial reports of a licensed charitable organization.
- 820 KAR 1:026. Quarterly reports of a licensed charitable gaming facility.
- 820 KAR 1:027. Quarterly reports of a licensed distributor.
- 820 KAR 1:029. Facility licensees.
- 820 KAR 1:044. Bingo equipment.
- 820 KAR 1:046. Bingo rules of play.
- 820 KAR 1:055. Charity fundraising event standards.
- 820 KAR 1:056. Special limited charity fundraising event standards.

CABINET FOR HEALTH AND FAMILY SERVICES

**Department for Public Health
Division of Maternal and Child Health**

Maternal and Child Health

902 KAR 4:030. Newborn Screening Program.

**Department for Medicaid Services
Division of Community Alternatives**

Certified Provider Requirements

907 KAR 7:005. Certified waiver provider requirements. (Not Amended After Comments) (Deferred from January 2014)

**Department for Medicaid Services
Division of Policy and Operations**

Medicaid Services

907 KAR 1:350. Coverage and payments for organ transplants.

Hospital Service Coverage and Reimbursement

907 KAR 10:825. Diagnosis-related group (DRG) inpatient hospital reimbursement.

**Commissioner's Office
Division of Healthcare Facilities Management**

Medicaid Eligibility

- 907 KAR 20:001 & E. Definitions for 907 KAR Chapter 20. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:005 & E. Medicaid technical eligibility requirements not related to a modified adjusted gross income standard or former foster care individuals. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:010 & E. Medicaid procedures for determining initial and continuing eligibility other than procedures related to a modified adjusted gross income eligibility standard or related to former foster care individuals. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:015 & E. Medicaid right to apply and reapply for individuals whose Medicaid eligibility is not based on a modified adjusted gross income eligibility standard or who are not former foster care individuals. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:020 & E. Income Standards for Medicaid other than Modified Adjusted Gross Income (MAGI) standards or for former foster care individuals. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:025 & E. Resource standards for Medicaid. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:030 & E. Trust and transferred resource requirements for Medicaid. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:035 & E. Spousal impoverishment and nursing facility requirements for Medicaid. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:040 & E. Relative responsibility requirements for Medicaid. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:045 & E. Special income requirements for hospice and home and community based services. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:050 & E. Presumptive eligibility. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:060 & E. Medicaid adverse action and conditions for recipients. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:075 & E. Eligibility provisions and requirements regarding former foster care individuals. ("E" expires 5/1/2014) (Amended After Comments)
- 907 KAR 20:100 & E. Modified Adjusted Gross Income (MAGI) Medicaid eligibility standards. ("E" expires 5/1/2014) (Amended After Comments)

**Department for Community Based Services
Division of Family Support**

K-TAP, Kentucky Works, Welfare to Work, State Supplementation

921 KAR 2:035. Right to apply and reapply.

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REMOVED FROM FEBRUARY 2014 AGENDA

**GENERAL GOVERNMENT CABINET
Kentucky Real Estate Appraisers Board**

Board

201 KAR 30:375. Appraisal procedures for appraisal management companies. (Amended After Comments) (Comments Received)

**CABINET FOR HEALTH AND FAMILY SERVICES
Division of Protection and Permanency**

Child Welfare

922 KAR 1:330. Child protective services. (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
103 KAR 3:010E

This emergency administrative regulation is being promulgated in order to provide Kentucky taxpayers the forms and information necessary to comply with Kentucky tax laws. This administrative regulation must be filed as soon as possible in order to incorporate by reference such tax forms and instructions as may be needed by taxpayers and their representatives to comply with Kentucky tax laws. An ordinary administrative regulation is not sufficient, because the public relies on these forms and instructions in order to make timely and accurate filing of tax returns and payment of the correct amount of tax due. This emergency administrative regulation shall be replaced by an ordinary administrative regulation which is being filed with the Regulations Compiler along with this emergency administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
THOMAS B. MILLER, Commissioner

FINANCE AND ADMINISTRATION CABINET
Department of Revenue
(Emergency Amendment)

103 KAR 3:010E. General Administrative Forms Manual.

RELATES TO: KRS 42.470, 61.870-61.884, 64.012, 131.010(9), 131.020, 131.030, 131.041, 131.051, 131.061, 131.081, 131.081(2), (9), (15), 131.110, 131.130, 131.130(3), (10), (11), 131.150, 131.155, 131.170, 131.181, 131.183, 131.190, 131.190(1), 131.240, 131.340, 131.500, 131.500(1), (2), (3), (9), (10), 131.510(1), (2)(a), (2)(b), 131.530, 131.540, 132.020, 132.130-132.160, 132.180, 132.190, 132.200, 132.220, 132.227, 132.230, 132.260, 132.270, 132.290, 132.310, 132.320, 132.450, 132.487, 132.510, 132.820, 132.990, 133.045, 133.110, 133.120, 133.130, 133.240, 134.020, 134.390, 134.420, 134.430, 134.440, 134.500, 134.580(4), 134.590, 134.800, 134.805, 134.810, 134.815, 134.820, 134.825, 134.830, 135.010, 135.020, 135.050, 136.020, 136.050, 136.070, 136.071, 136.0704, 136.090, 136.100, 136.115-136.180, 136.1873, 136.310, 136.320, 136.330, 136.335, 136.377, 136.392, 136.545, 136.575, 136.600-136.660, 137.130, 137.160, 138.448, 138.885, 139.185, 139.200, 139.240, 139.330, 139.390, 139.550, 141.0401(5), 141.0401(6), 141.050(4), 141.210, 141.235, 141.340(2), 142.010, 142.050, 142.321, 142.327, 142.357, 143.030(1), 143.037, 143.040, 143.050, 143.060(1), 143.085, 143.990, 143A.010, 143A.030, 143A.035, 143A.037, 143A.080, 143A.090, 143A.100(1), 143A.991, 154.22-050, 154.22-060, 154.22-070, 154.23-010, 154.24-110, 154.24-130, 154.26-090, 154.28-090, 154.34-010, 155.170, 160.613-160.617, 160.6154(3), 205.745, 209.160, 224.01-310(1), 234.321, 234.370, 243.710, 243.720, 243.730, 243.850, 243.884, 248.756(2), 299.530, 304.4-030, 304.11-050, 304.49-220, 351.175, 395.470(3), 413.120.

STATUTORY AUTHORITY: KRS 131.130(3)

EFFECTIVE: December 27, 2013

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue Forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

Section 1. Administrative - Required Forms. (1) Revenue Form 10A001, "Request to Inspect Public Records", shall be completed by the public to request access to public records specified on the form.

(2) Revenue Form 10A020, "Waiver of Appeal Rights", shall be completed by a taxpayer to reopen an audit that has become final if the taxpayer has failed to timely file a protest with the Department of Revenue.

(3) Revenue Form 10A070, "Authorization Agreement for Electronic Funds Transfer", shall be completed by taxpayers to authorize the Department of Revenue to move funds by electronic means from taxpayer accounts to the Department of Revenue as payment for taxes.

(4) Revenue Form 10A071, "EFT Bank Change", shall be completed by taxpayers who are registered as EFT ACH Debit filers to notify the department of a bank account change.

(5) Revenue Form 10A100(P), "Kentucky Tax Registration Application and Instructions", shall:

(a) Be used by taxpayers to voluntarily apply for tax registration of the following accounts:

1. Employer's Kentucky withholding tax;
2. Corporation income tax;
3. Sales and use tax;
4. Consumer's use tax;
5. Motor vehicle tire fee;
6. Transient room tax;
7. Limited liability entity tax;
8. Utility Gross Receipts License tax;
9. Telecommunications tax;
10. Coal severance and processing tax; or
11. Coal Seller/Purchaser Certificate ID Number; and

(b) Provide the department the necessary information to properly register the taxpayer for all applicable tax accounts, including the legal business name, federal employer identification number (FEIN), address and other demographic information for the business, and each responsible party's information including full name, social security number, and residential address.

(6) Revenue Form 10A100-CS(P), "Kentucky Tax Registration Application and Instructions", shall:

(a) Be sent by the department's Division of Registration and Data Integrity to non-compliant taxpayers for the taxpayers to apply for tax registration of the following accounts:

1. Employer's Kentucky withholding tax;
2. Corporation income tax;
3. Sales and use tax;
4. Consumer's use tax;
5. Motor vehicle tire fee;
6. Transient room tax;
7. Limited liability entity tax;
8. Utility Gross Receipts License tax;
9. Telecommunications tax;
10. Coal severance and processing tax; or
11. Coal Seller/Purchaser Certificate ID Number; and

(b) Provide the department the necessary information to properly register the taxpayer for all applicable tax accounts, including the legal business name, federal employer identification number (FEIN), address and other demographic information for the business, and each responsible party's information including full name, social security number, and residential address.

(7) Revenue Form 10A104, "Update or Cancellation of Kentucky Tax Account(s)", shall:

(a) Be used by the taxpayer to update business information or to cancel accounts for the following taxes:

1. Employer's Kentucky withholding tax;
2. Corporation income tax;
3. Sales and use tax;
4. Consumer's use tax;
5. Motor vehicle tire fee;
6. Transient room tax;
7. Limited liability entity tax;
8. Utility Gross Receipts License tax;
9. Telecommunications tax; or
10. Coal severance and processing tax; and

(b) Provide the department the necessary information to

properly update and maintain demographic information of the business for all applicable tax accounts, including the legal business name, federal employer identification number (FEIN), address and other demographic information for the business, and each responsible party's information including full name, social security number, and residential address.

(8) Revenue Form 10A104-I, "Instructions Update or Cancellation of Kentucky Tax Account(s)", shall provide instructions for the proper completion of Revenue Form 10A104.

(9) Revenue Form 10A106, "Appointment of Taxpayer Administrator and Authorized Users for Kentucky Online Tax", shall be used to establish a taxpayer administrator and authorized users for use of the Kentucky Online Tax System.

(10) Revenue Form 10A2000, "Request for Return/Information", shall be used to request information from the disclosure office as an inter-agency request or as a request from an outside agency.

(11) Revenue Form 10F060, "Electronic Funds Transfer Program: ACH Credit Guide", shall provide information on the specific requirements of the Department of Revenue's Credit Method of tax remittance for the Electronic Funds Transfer Program.

(12) Revenue Form 10F061, "Electronic Funds Transfer Program: Debit Guide", shall provide instructions to the taxpayer on how to authorize the Department of Revenue to electronically debit a taxpayer controlled account in an Automated Clearing House participating financial institution for the amount which the taxpayer reports to the state's data collection service.

(13) Revenue Form 10F100, "Your Rights As a Kentucky Taxpayer", shall provide the public with information describing taxpayer rights provided by KRS Chapters 131, 133, and 134.

(14) Revenue Form 12A012, "Receipt of Seized Property", shall be presented for execution to the taxpayer receiving returned property from the Kentucky Department of Revenue that was previously seized for failure to pay taxes in order to establish documentation that the property was returned to the taxpayer.

(15) Revenue Form 12A018, "Kentucky Department of Revenue Offer in Settlement Application", shall be presented for execution to persons requesting to settle their tax liabilities for less than the delinquent tax liability based upon doubt as to collectability or doubt as to liability.

(16) Revenue Form 12A104, "Notice of Seizure", shall be presented to the owner or officer of the entity from which the Kentucky Department of Revenue is seizing property for failure to pay taxes owed to the Commonwealth.

(17) Revenue Form 12A107, "Notice of Sale", shall be presented to the owner of seized property, published in the newspaper with the highest circulation for that area, and posted at the courthouse, at three (3) other public places within the county, and where the seizure was made, for the purpose of notifying the property owner, and advertising to the public the sale of the seized property.

(18) Revenue Form 12A109-1, "Release of Bank Levy", shall be presented to the bank on which the levy was served for the purpose of releasing the seized property.

(19) Revenue Form 12A109-2, "Release of Levy", shall be presented to the party on which the levy was served for the purpose of releasing the seized property.

(20) Revenue Form 12A109-3, "Release of Levy", shall be presented to the party on which the levy was served for the purpose of releasing the seized property related to child support.

(21) Revenue Form 12A110, "Release of Levy on Wages, Salary, and Other Income", shall be presented to an employer for the purpose of releasing a wage levy.

(22) Revenue Form 12A110-1, "Release of Levy on Wages, Salary, and Other Income", shall be presented to an employer for the purpose of releasing a wage levy related to child support.

(23) Revenue Form 12A500, "Certificate of Partial Discharge of Tax Lien", shall be presented to anyone who makes a proper application for a lien release on a specific piece of property if the Department of Revenue's lien attaches no equity or if the equity that the lien encumbers is paid to the Department of Revenue.

(24) Revenue Form 12A501, "Certificate of Subordination of

Kentucky Finance and Administration Tax Lien", shall be presented to anyone who makes proper application requesting that the Department of Revenue subordinate its lien position to a new mortgage and demonstrates that the subordination is in the Commonwealth's best interest.

(25) Revenue Form 12A502, "Application for Certificate of Subordination of Kentucky Tax Lien", shall be presented to anyone who requests to have the Department of Revenue subordinate its lien position to a new mortgage.

(26) Revenue Form 12A503, "Application for Specific Lien Release", shall be presented to anyone who requests that the Department of Revenue release its tax lien so that a specific piece of property can be sold.

(27) Revenue Form 12A504, "Personal Assessment of Corporate Officer or LLC Manager", shall be presented to a corporate officer for the purpose of establishing responsibility of payment of trust taxes owed to the Commonwealth.

(28) Revenue Form 12A505, "Waiver Extending Statutory Period of Assessment of Corporate Officer or LLC Manager", shall be presented to the corporate officers or LLC managers for the purpose of entering into a payment agreement to pay the trust taxes owed to the Commonwealth, and the terms of the payment agreement shall extend past the statutory period for assessing responsible corporate officers or LLC managers.

(29) Revenue Form 12A506, "Waiver Extending Statutory Period for Collection", shall be presented to the taxpayer for the purpose of extending the period in which the liability can be collected.

(30) Revenue Form 12A507, "Table for Figuring the Amount Exempt From Levy on Wages, Salary, and Other Income", shall be presented to employers with a wage levy on an employee for the purpose of calculating the dollar amount of wages due to the employee.

(31) Revenue Form 12A508-1, "Notice of Tax Due", shall be presented for the purpose of assessing an officer of a corporation who is personally liable for trust taxes owed to the Commonwealth.

(32) Revenue Form 12A508-2, "Notice of Tax Due", shall be presented for the purpose of assessing an officer of a corporation who is personally liable for Gasoline and Special Fuels taxes owed to the Commonwealth.

(33) Revenue Form 12A508-3, "Notice of Tax Due", shall be presented for the purpose of assessing a manager or partner of a limited liability company who is personally liable for trust taxes owed to the Commonwealth.

(34) Revenue Form 12A508-4, "Notice of Tax Due", shall be presented for the purpose of assessing a manager or partner of a limited liability company who is personally liable for Gasoline and Special Fuels taxes owed to the Commonwealth.

(35) Revenue Form 12A514, "Questionnaire for Persons Relative to a Notice of Assessment", shall be presented to an officer of a corporation for the purpose of resolving responsibility of the trust taxes owed to the Commonwealth.

(36) Revenue Form 12A517, "Notice of Lien", shall be presented to the county clerk for appropriate recording and to the taxpayer against whom the lien is filed for the purpose of filing and recording the tax lien in the county clerk's office and giving notification to the taxpayer.

(37) Revenue Form 12A517-1, "Notice of Child Support Lien", shall be presented to the county clerk for appropriate recording and to the taxpayer against whom the lien is filed for the purpose of filing and recording the tax lien in the county clerk's office and giving notification to the taxpayer.

(38) Revenue Form 12A518, "Certificate of Release of Lien", shall be presented to the county clerk and to the taxpayer against whom the tax lien is filed for the purpose of releasing the lien and notifying the taxpayer of the release.

(39) Revenue Form 12A518-1, "Certificate of Release of Child Support Lien", shall be presented to the county clerk and to the taxpayer against whom the child support lien is filed for the purpose of releasing the lien and notifying the obligor of the release.

(40) Revenue Form 12A638, "Statement of Financial Condition for Individuals", shall be presented to individuals requesting to

make payments or settle their tax liability to the Commonwealth for the purpose of establishing the financial ability to make payments or settle.

(41) Revenue Form 12A638(I), "Instructions for Completing Statement of Financial Condition for Individuals", shall provide instructions for completing Revenue Form 12A638.

(42) Revenue Form 12A639, "Statement of Financial Condition for Businesses", shall be presented to business owners requesting to make payments or settle a tax liability to the Commonwealth for the purpose of establishing the financial ability to make payments or settle.

(43) Revenue Form 12A639(I), "Instructions for Completing Statement of Financial Condition for Businesses", shall provide instructions for completing Revenue Form 12A639.

(44) Revenue Form 12B019, "Notice of Levy on Wages, Salary, and Other Income", shall be presented to employers for the purpose of levying wages from an employee who owes taxes to the Kentucky Department of Revenue.

(45) Revenue Form 12B019-1, "Notice of Levy on Wages, Salary, and Other Income", shall be presented to employers for the purpose of levying wages from an employee who owes child support.

(46) Revenue Form 12B020, "Notice of Levy", shall be presented to banks for the purpose of levying bank accounts of taxpayers who owe taxes to the Kentucky Department of Revenue.

(47) Revenue Form 12B020-2, "Notice of Levy", shall be presented to banks for the purpose of levying bank accounts of obligors who owe child support.

(48) Revenue Form 21A020, "Request for Copy of Tax Refund Check", shall be completed and submitted to the Department of Revenue in order to obtain a copy of a cashed refund check.

(49) Revenue Form 30A005, "Temporary Vendor's Sales Tax Permit", shall be presented to temporary and transient vendors who do not have a permanent place of business for the purpose of remitting tax on a non-permit basis, as required by 103 KAR 25:060.

(50) Revenue Form 30A006, "Temporary Vendor Sales and Use Tax Return/Processing Document", shall be used to register temporary vendors who do business in the Commonwealth of Kentucky.

(51) Revenue Form 30A872, "Record of Money Receipt Issued", shall be used by Department of Revenue Field personnel to provide written documentation of acceptance of cash payments.

(52) Revenue Form 31A001, "Vendor Contact Authorization", shall be used by a Department of Revenue representative to obtain permission from a taxpayer to contact his or her vendors concerning the issuance of exemption certificates.

(53) Revenue Form 31A004, "Auditor Record of Money Receipt Issued", shall be used by the auditor to acknowledge payment from taxpayers of taxes determined to be tentatively due at the time of an audit.

(54) Revenue Form 31A011-ASH, "Taxpayer Data Questionnaire", shall be used by auditors at the Ashland Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(55) Revenue Form 31A011-BG, "Taxpayer Data Questionnaire", shall be used by auditors at the Bowling Green Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(56) Revenue Form 31A011-CKY, "Taxpayer Data Questionnaire", shall be used by auditors at the Central Kentucky Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(57) Revenue Form 31A011-COR, "Taxpayer Data Questionnaire", shall be used by auditors at the Corbin Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(58) Revenue Form 31A011-HOP, "Taxpayer Data Questionnaire", shall be used by auditors at the Hopkinsville

Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(59) Revenue Form 31A011-LOU, "Taxpayer Data Questionnaire", shall be used by auditors at the Louisville Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(60) Revenue Form 31A011-NKY, "Taxpayer Data Questionnaire", shall be used by auditors at the Northern Kentucky Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(61) Revenue Form 31A011-OWEN, "Taxpayer Data Questionnaire", shall be used by auditors at the Owensboro Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(62) Revenue Form 31A011-PAD, "Taxpayer Data Questionnaire", shall be used by auditors at the Paducah Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(63) Revenue Form 31A011-PIKE, "Taxpayer Data Questionnaire", shall be used by auditors at the Pikeville Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(64) Revenue Form 31A012, "Interstate Sales/Income Tax Questionnaire", shall be used to establish possible taxing jurisdiction for sales and use tax and income tax for the states of Ohio and Indiana.

(65) Revenue Form 31A014, "SEATA - Southeastern Association of Tax Administrators Nexus Questionnaire", shall be used to establish possible taxing jurisdiction for sales and use tax and income tax for the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Tennessee, Virginia and West Virginia.

(66) Revenue Form 31A020, "Office of Field Operations Request for Copy of Tax Return(s)", shall be used by Department of Revenue representatives to obtain permission from a taxpayer to release tax returns.

(67) Revenue Form 31A050, "Electronic Transmittal Authorization", shall be used by auditors to seek permission from a taxpayer to transmit audit results electronically.

(68) Revenue Form 31A110, "Office of Field Operations Estimated/Jeopardy Assessment", shall be used for Taxpayer Service Centers to request approval to submit estimated/jeopardy assessments.

(69) Revenue Form 31A114, "Property Audit Request", shall be used by PVAs to submit audit requests for property tax.

(70) Revenue Form 31A115, "Agreement Fixing Test Periods", shall be used by auditors to establish certain test periods when conducting an audit.

(71) Revenue Form 31A149, "Agreement Fixing Period of Limitation Upon Assessment of Sales, Use or Severance Tax", shall be completed by a taxpayer and a representative of the Kentucky Department of Revenue whereby both parties consent and agree that certain sales, use or severance tax deficiencies or overpayments for specific periods may be assessed or refunded beyond the normal four (4) year statute of limitations.

(72) Revenue Form 31A150, "Agreement Fixing Period of Limitation Upon Assessment of Utility Gross Receipts License Tax", shall be used by auditors to establish taxable periods to be held open for audit and date of assessment.

(73) Revenue Form 31A151, "Agreement Fixing Period of Limitation Upon Assessment of Sales or Use for Authorized EDP Holders", shall be used to document an agreement fixing period of audit for sales or use tax field audits for EDP holders.

(74) Revenue Form 31A200, "Reporting Agreement", shall be used to document an agreement between the Department of Revenue and taxpayer regarding sales tax.

~~(75)~~(74) Revenue Form 31A685, "Authorization to Examine

Bank Records", shall be used by the Department of Revenue to obtain permission from a taxpayer to examine records in connection with transactions at the taxpayer's bank.

(76)(75) Revenue Form 31A800, "IT Review History Document", shall be used to record interaction with the taxpayer during an individual income tax review conducted by compliance officers.

(77)(76) Revenue Form 31A725, "Statute of Limitations Agreement", shall be completed by a taxpayer and a representative of the Kentucky Department of Revenue whereby both parties consent and agree that certain income tax deficiencies or overpayments for specific periods may be assessed or refunded beyond the normal four (4) year statute of limitations.

(78)(77) Revenue Form 31F006, "Southeastern States Information Exchange Program", shall be used to provide information to taxpayers concerning the information exchange program between the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Tennessee, Virginia, and West Virginia.

(79)(78) Revenue Form 31F010, "Kentucky's Computer Assisted Audit Program", shall be the brochure used as instructions for taxpayers who submit tax records in an electronic format.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Revenue Form 10A001, "Request to Inspect Public Records", February 1997;

(b) Revenue Form 10A020, "Waiver of Appeal Rights", January 2001;

(c) Revenue Form 10A070, "Authorization Agreement for Electronic Funds Transfer", January 2008;

(d) Revenue Form 10A071, "EFT Bank Change", June 2009;

(e) Revenue Form 10A100(P), "Kentucky Tax Registration Application and Instructions", July 2013[August 2012];

(f) Revenue Form 10A100-CS(P), "Kentucky Tax Registration Application and Instructions", July 2013[August 2012];

(g) Revenue Form 10A104, "Update or Cancellation of Kentucky Tax Account(s)", June 2011;

(h) Revenue Form 10A104-I, "Instructions Update or Cancellation of Kentucky Tax Account(s)", June 2011;

(i) Revenue Form 10A106, "Appointment of Taxpayer Administrator and Authorized Users for Kentucky Online Tax", May 2010;

(j) Revenue Form 10A2000, "Request for Return/Information", October 2011;

(k) Revenue Form 10F060, "Electronic Funds Transfer Program: ACH Credit Guide", April 2006;

(l) Revenue Form 10F061, "Electronic Funds Transfer Program: Debit Guide", December 2008;

(m) Revenue Form 10F100, "Your Rights as a Kentucky Taxpayer", July 2013[October 2010];

(n) Revenue Form 12A012, "Receipt of Seized Property", November 2006;

(o) Revenue Form 12A018, "Kentucky Department of Revenue Offer in Settlement Application", August 2012[June 2011];

(p) Revenue Form 12A104, "Notice of Seizure", October 1982;

(q) Revenue Form 12A107, "Notice of Sale", January 2000;

(r) Revenue Form 12A109-1, "Release of Bank Levy", September 2004;

(s) Revenue Form 12A109-2, "Release of Levy", January 2000;

(t) Revenue Form 12A109-3, "Release of Levy", January 2008;

(u) Revenue Form 12A110, "Release of Levy on Wages, Salary, and Other Income", September 2004;

(v) Revenue Form 12A110-1, "Release of Levy on Wages, Salary, and Other Income", January 2008;

(w) Revenue Form 12A500, "Certificate of Partial Discharge of Tax Lien", June 2006;

(x) Revenue Form 12A501, "Certificate of Subordination of Kentucky Finance and Administration Tax Lien", June 2006;

(y) Revenue Form 12A502, "Application for Certificate of Subordination of Kentucky Tax Lien", October 2006;

(z) Revenue Form 12A503, "Application for Specific Lien Release", October 2006;

(aa) Revenue Form 12A504, "Personal Assessment of Corporate Officer or LLC Manager", June 2003;

(bb) Revenue Form 12A505, "Waiver Extending Statutory Period of Assessment of Corporate Officer or LLC Manager", June 2003;

(cc) Revenue Form 12A506, "Waiver Extending Statutory Period for Collection", June 2003;

(dd) Revenue Form 12A507, "Table for Figuring the Amount Exempt from Levy on Wages, Salary, and Other Income", November 2006;

(ee) Revenue Form 12A508-1, "Notice of Tax Due", January 2008;

(ff) Revenue Form 12A508-2, "Notice of Tax Due", January 2008;

(gg) Revenue Form 12A508-3, "Notice of Tax Due", November 2008;

(hh) Revenue Form 12A508-4, "Notice of Tax Due", November 2008;

(ii) Revenue Form 12A514, "Questionnaire for Persons Relative to a Notice of Assessment", August, 1996;

(jj) Revenue Form 12A517, "Notice of Lien", November 2011;

(kk) Revenue Form 12A517-1, "Notice of Child Support Lien", November 2008;

(ll) Revenue Form 12A518, "Certificate of Release of Lien", November 2008;

(mm) Revenue Form 12A518-1, "Certificate of Release of Child Support Lien", January 2008;

(nn) Revenue Form 12A638, "Statement of Financial Condition for Individuals", July 2004;

(oo) Revenue Form 12A638(I), Instructions for Completing Statement of Financial Condition for Individuals", August 2004;

(pp) Revenue Form 12A639, "Statement of Financial Condition for Businesses", August 2004;

(qq) Revenue Form 12A639(I), "Instructions for Completing Statement of Financial Condition for Businesses", August 2004;

(rr) Revenue Form 12B019, "Notice of Levy on Wages, Salary, and Other Income", September 2004;

(ss) Revenue Form 12B019-1, "Notice of Levy on Wages, Salary, and Other Income", September 2011;

(tt) Revenue Form 12B020, "Notice of Levy", September 2004;

(uu) Revenue Form 12B020-2, "Notice of Levy", January 2008;

(vv) Revenue Form 21A020, "Request for Copy of Tax Refund Check", November 2011[October 2006];

(ww) Revenue Form 30A005, "Temporary Vendor's Sales Tax Permit", September 1998;

(xx) Revenue Form 30A006, "Temporary Vendor Sales and Use Tax Return/Processing Document", December 2006;

(yy) Revenue Form 30A872, "Record of Money Receipt Issued", October 2000;

(zz) Revenue Form 31A001, "Vendor Contact Authorization", July 2006;

(aaa) Revenue Form 31A004, "Auditor Record of Money Receipt Issued", July 2006;

(bbb) Revenue Form 31A011-ASH, "Taxpayer Data Questionnaire", December 2011;

(ccc) Revenue Form 31A011-BG, "Taxpayer Data Questionnaire", December 2011;

(ddd) Revenue Form 31A011-CKY, "Taxpayer Data Questionnaire", December 2011;

(eee) Revenue Form 31A011-COR, "Taxpayer Data Questionnaire", December 2011;

(fff) Revenue Form 31A011-HOP, "Taxpayer Data Questionnaire", December 2011;

(ggg) Revenue Form 31A011-LOU, "Taxpayer Data Questionnaire", December 2011;

(hhh) Revenue Form 31A011-NKY, "Taxpayer Data Questionnaire", December 2011;

(iii) Revenue Form 31A011-OWEN, "Taxpayer Data Questionnaire", December 2011;

(jjj) Revenue Form 31A011-PAD, "Taxpayer Data Questionnaire", December 2011;

(kkk) Revenue Form 31A011-PIKE, "Taxpayer Data Questionnaire", December 2011;

(lll) Revenue Form 31A012, "Interstate Sales/Income Tax Questionnaire", July 2006;

(mmm) Revenue Form 31A014, "SEATA - Southeastern Association of Tax Administrators Nexus Questionnaire", July 2006;

(nnn) Revenue Form 31A020, "Office of Field Operations Request for Copy of Tax Return(s)", July 2006;

(ooo) Revenue Form 31A050, "Electronic Transmittal Authorization", March 2011;

(ppp) Revenue Form 31A110, "Office of Field Operations Estimated/Jeopardy Assessment", June 2012;

(qqq) Revenue Form 31A114, "Property Audit Request", November 2011;

(rrr) Revenue Form 31A115, "Agreement Fixing Test Periods", April 2008;

(sss) Revenue Form 31A149, "Agreement Fixing Period of Limitation Upon Assessment of Sales, Use or Severance Tax", July 2006;

(ttt) Revenue Form 31A150, "Agreement Fixing Period of Limitation Upon Assessment of Utility Gross Receipts License Tax", May 2008;

(uuu) Revenue Form 31A151, "Agreement Fixing Period of Limitation Upon Assessment of Sales or Use For Authorized EDP Holders", June 2013;

(vvv) Revenue Form 31A200, "Reporting Agreement", November 2011;

(www)(vvv) Revenue Form 31A685, "Authorization to Examine Bank Records", May 1985;

(xxx)(www) Revenue Form 31A800, "IIT Review History Document", November 2011;

(yyv)(xxx) Revenue Form 31A725, "Statute of Limitations Agreement", July 2006;

(zzz)(yyy) Revenue Form 31F006, "Southeastern States Information Exchange Program", March 2012; and

(aaa)(zzz) Revenue Form 31F010, "Kentucky's Computer Assisted Audit Program", May 2010.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40620, or at any Kentucky Department of Revenue Taxpayer Service Center, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 from 10:00 a.m. to 12:00 p.m., in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 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 February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Department of Revenue, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9826, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order for the Department of Revenue to meet the requirements of KRS 13A.110 which requires that forms required to be submitted by a regulated entity shall be included in an administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation incorporates by reference the required revenue forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

(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 corrects the existing regulation to add new or update existing Department of Revenue forms.

(b) The necessity of the amendment to this administrative regulation: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. Any addition of new forms or a change to existing forms must result in an amendment of the associated regulation to keep it current.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of the tax laws.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide taxpayers with the current version of the forms listed herein.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All Kentucky taxpayers and their representatives will be affected by the listing of all forms administered by the Department of Revenue in an administrative regulation. Local government will be affected to the extent they utilize forms administered by the Department of Revenue. The Department of Revenue will be affected to the extent that it administers the referenced forms.

(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 will have to be taken by the taxpayers or local governments to comply with 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): There would be no cost incurred by the taxpayer or local government.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Access to current forms and instructions will enable taxpayers to comply with tax laws.

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

(a) Initially: The Department of Revenue will not incur

additional costs as the result of this regulation.

(b) On a continuing basis: The Department of Revenue will not incur additional costs as the result of this regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Department of Revenue agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: This administrative regulation does not require an increase in fees or funding.

(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 either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied because the requirements of this regulation apply to every taxpayer.

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 Revenue within the Finance and Administration Cabinet.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 131.130(3).

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No additional cost.

(d) How much will it cost to administer this program for subsequent years? No additional 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:

STATEMENT OF EMERGENCY

103 KAR 3:020E

This emergency administrative regulation is being promulgated in order to provide Kentucky taxpayers the forms and information necessary to comply with Kentucky tax laws. This administrative regulation must be filed as soon as possible in order to incorporate by reference such tax forms and instructions as may be needed by taxpayers and their representative to comply with Kentucky tax laws. An ordinary administrative regulation is not sufficient, because the public relies on these forms and instructions in order to make timely and accurate filing of tax returns and payment of the correct amount of tax due. This emergency administrative regulation shall be replaced by an ordinary administrative regulation which is being filed with the Regulations Compiler along with this emergency administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

THOMAS B. MILLER, Commissioner

FINANCE AND ADMINISTRATION CABINET Department of Revenue Office of Sales and Excise Taxes (Emergency Amendment)

103 KAR 3:020E. Sales and Telecommunications Forms Manual.

RELATES TO: KRS 61.870-61.884, 131.010-131.130, 131.150-131.240, 134.580, 136.600-136.660, 139.010-139.795, 144.132, 144.137, 154.20-206, 160.613-160.617, 224.01-310, 247.920

STATUTORY AUTHORITY: KRS 131.130(3)

EFFECTIVE: December 27, 2013

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue Forms used in the administration of Sales and Use Taxes and Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

Section 1. Sales and Use Tax - Required Forms. (1) Revenue Form 51A101(a), Sales and Use Tax Permit, shall be conspicuously displayed by the sales and use tax permit holder at the location for which the permit was issued.

(2) Revenue Form 51A101(b), Sales and Use Tax Permit Update, shall be issued by the Department of Revenue to update the Sales and Use Tax Permit with business name and address change information.

(3) Revenue Form 51A101(c)(1), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit, shall be issued to Model 1 Streamlined Sales and Use Tax filers registered in Kentucky and shall be conspicuously displayed by the SST permit holder at the location for which the permit was issued.

(4) Revenue Form 51A101(c)(2), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit, shall be issued to Model 2 Streamlined Sales and Use Tax filers registered in Kentucky and shall be conspicuously displayed by the SST permit holder at the location for which the permit was issued.

(5) Revenue Form 51A101(c)(4), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit, shall be issued to Model 4 Streamlined Sales and Use Tax filers registered in Kentucky and shall be conspicuously displayed by the SST permit holder at the location for which the permit was issued.

(6) Revenue Form 51A101(d), Sales and Use Tax Permit Update (SST), shall be issued by the Department of Revenue to update the Kentucky Streamlined Sales and Use Tax (SST) Filing Permit with business name and address change information.

(7) Revenue Form 51A102, Kentucky Sales and Use Tax Worksheet, shall be submitted to the Department of Revenue by a Kentucky sales and use tax permit holder to report total receipts, itemized deductions, amount subject to Kentucky use tax and total amount of Kentucky sales and use tax due for a particular reporting period.

(8) Revenue Form 51A102E, Kentucky Sales and Use Tax Worksheet - Electronic Funds Transfer, shall be submitted to the Department of Revenue by a Kentucky sales and use tax permit holder who remits payment via electronic funds transfer to report total receipts, itemized deductions, amount subject to Kentucky use tax and total amount of Kentucky sales and use tax due for a particular reporting period.

(9) Revenue Form 51A103, Kentucky Accelerated Sales and Use Tax Worksheet, shall be completed by a Kentucky sales and use tax permit holder who has been designated as an accelerated filer to report total receipts, itemized deductions, amount subject to use tax, and total amount of sales and use tax due.

(10) Revenue Form 51A103E, Kentucky Accelerated Sales and Use Tax Worksheet - Electronic Funds Transfer, shall be submitted on a monthly basis by a Kentucky sales and use tax permit holder to report total receipts, itemized deductions, amount

subject to use tax, and total amount of sales and use tax due on an accelerated basis and remitted via electronic funds transfer.

(11) Revenue Form 51A105, Resale Certificate, shall be presented to a seller by a Kentucky sales and use tax permit holder to claim that the tangible personal property or digital property purchased from the seller will be:

- (a) Resold in the regular course of business;
- (b) Leased or rented; or
- (c) Used as raw material, industrial supply or industrial tool.

(12) Revenue Form 51A109, Application for Energy Direct Pay Authorization (Sales and Use Tax and Utility Gross Receipts License Tax), shall be filed with the Department of Revenue by a manufacturer, processor, miner or refiner to apply for an energy direct pay authorization.

(13) Revenue Form 51A110, Direct Pay Authorization, shall be presented to a Kentucky sales and use tax permit holder by a company authorized to report and pay directly to the Department of Revenue the sales or use tax on all purchases of tangible personal property, or digital property excluding energy and energy-producing fuels.

(14) Revenue Form 51A111, Certificate of Exemption Machinery for New and Expanded Industry, shall be presented to a Kentucky sales and use tax permit holder by a manufacturer or production processor to claim exemption from sales and use tax.

(15) Revenue Form 51A112, Application for Direct Pay Authorization, shall be submitted by a registered sales and use tax permit holder wishing to obtain a direct pay authorization.

(16) Revenue Form 51A113, Kentucky Consumer's Use Tax Worksheet, shall be completed by a registered consumer's use tax permit holder and submitted to the Department of Revenue on a regular basis to report the amount of purchases of tangible personal property or digital property subject to Kentucky use tax.

(17) Revenue Form 51A113(O), Consumer's Use Tax Return, shall be completed by a person storing, using, or otherwise consuming tangible personal property or digital property in Kentucky who is not registered for a consumer's use tax permit number.

(18) Revenue Form 51A115, Order for Selected Sales and Use Tax Publications, shall be presented to the Department of Revenue by anyone who wishes to order selected sales and use tax forms and regulations.

(19) Revenue Form 51A116, Use Tax Compliance Inquiry Worksheet, shall be completed by a purchaser of Watercraft, Aircraft, or other tangible or digital property to document if the purchase of the property is subject to the Kentucky Use Tax.

(20) Revenue Form 51A125, Application for Purchase Exemption Sales and Use Tax, shall be presented to the Department of Revenue by a resident 501C(3) charitable, educational, or religious institution; historical sites; and units of federal, state or local governments to apply for a sales and use tax exemption on purchases of tangible personal property, digital property, or certain services to be utilized in the exempt entity's function.

(21) Revenue Form 51A126, Purchase Exemption Certificate, shall be presented to a retailer by a resident charitable, educational or religious institution or Kentucky historical site to claim exemption from sales and use tax on purchases of tangible personal property, digital property, or services.

(22) Revenue Form 51A127, Out-of-State Purchase Exemption Certificate, shall be presented to a retailer by an out-of-state agency or institution that is qualified for exemption in their state of residence.

(23) Revenue Form 51A128, Solid Waste Recycling Machinery Exemption Certificate, shall be presented to a retailer by a business or organization that claims exemption from sales and use tax on the purchase, lease or rental of machinery or equipment to be primarily used for recycling purposes to collect, source separate, compress, bale, shred or otherwise handle waste material.

(24) Revenue Form 51A129, Kentucky Sales and Use Tax Energy Exemption Annual Return, shall be submitted to the Department of Revenue by an energy direct pay holder to reconcile the actual amount of sales and use tax due on purchases of

energy and energy-producing fuels to the total amount of sales and use tax paid based upon previous estimates of tax due.

(25) Revenue Form 51A130, Kentucky Sales and Use Tax Monthly Aviation Fuel Tax Credit Schedule of Qualified Certificated Air Carriers, shall be completed by a qualified certificated air carrier on a monthly basis to claim an aviation fuel tax credit against the company's sales and use tax liability for the month.

(26) Revenue Form 51A131, Kentucky Sales and Use Tax Monthly Aviation Fuel Dealer Supplementary Schedule, shall be completed by aviation fuel dealers selling aviation fuel in order to determine the sales and use tax collected and remitted on the sale of aviation fuel, including jet fuel.

(27) Revenue Form 51A132, Kentucky Sales and Use Tax Equine Breeders Supplementary Schedule, shall be completed by an equine breeder to report taxable receipts from equine breeding fees.

(28) Revenue Form 51A135, Kentucky Sales Tax Motor Vehicle Sales Supplementary Schedule, shall be completed by motor vehicle dealers who collect Kentucky sales tax on the sale of motor vehicles to residents of states who subject Kentucky residents to sales upon the purchase of motor vehicles in their states.

(29) Revenue Form 51A143, Purchase Exemption Certificate - Watercraft Industry, shall be presented to a retailer by a purchaser to claim exemption from sales and use tax on the purchase of tangible personal property that will be used for the direct operation of watercraft in the activity of transporting property or in conveying persons for hire.

(30) Revenue Form 51A149, Certificate of Exemption for Pollution Control Facilities, shall be presented to a retailer by a holder of a pollution control tax exemption certificate or jointly by a contractor and the holder of a pollution control tax exemption certificate to claim exemption from sales and use tax on the purchase of materials and equipment that will become part of a certified pollution control facility.

(31) Revenue Form 51A150, Aircraft Exemption Certificate, shall be presented to a retailer by a purchaser to claim exemption from sales and use tax on the purchase of aircraft, repair and replacement parts for the aircraft, and supplies that will be used for the direct operation of aircraft in interstate commerce and used exclusively for the conveyance of property or passengers for hire.

(32) Revenue Form 51A154, Certificate of Exemption Out-of-State Delivery for Aircraft, All Terrain Vehicle (ATV), Mobile/Manufactured Homes, Campers, Boats, Motors or Trailers, shall be completed in triplicate by the seller and buyer when the sale of the tangible personal property occurs and the seller makes delivery of the tangible personal property out of state, and also completes the affidavit portion of the form within two (2) days of the time of delivery to claim that the property was purchased exempt from sales tax and delivered immediately out of state not to return to Kentucky for use.

(33) Revenue Form 51A157, Certificate of Exemption - Water Used in Raising Equine, shall be presented to a retailer by a person regularly engaged in raising equine as a business to claim exemption for the purchase of water used to raise equine.

(34) Revenue Form 51A158, Farm Exemption Certificate, shall be presented to a retailer by a person regularly engaged in the occupation of tilling and cultivating the soil for the production of crops, raising and feeding livestock or poultry; or raising and feeding llamas, alpacas, ratties, buffalo, aquatic organisms, or cervids to claim exemption from sales and use tax on the purchase of certain tangible personal property.

(35) Revenue Form 51A159, On-Farm Facilities Certificate of Exemption for Materials, Machinery and Equipment, shall be presented to a retailer by a farmer or jointly by a farmer and a contractor to claim exemption from sales and use tax on the purchase of materials, machinery and equipment which will be incorporated into the construction, repair, or renovation of on-farm facilities exempt under the provisions of KRS 139.480.

(36) Revenue Form 51A160, Application for Truck Part Direct Pay Authorization, shall be filed with the Department of Revenue by the owner of a motor vehicle, including a towed unit, qualifying for the repair and replacement part exemption provided under KRS

139.480(32)(a) to apply for the truck part direct pay authorization.

(37) Revenue Form 51A161, Truck Part Direct Pay Authorization, shall be issued by the Department of Revenue to authorize motor carriers to report and pay directly to the department the sales and use tax on all purchases of repair and replacement parts for motor vehicles and to authorize retailers to sell motor vehicle repair and replacement parts directly to the authorized motor carrier without receipt of sales and use tax.

(38) Revenue Form 51A163, Application for Charter Bus Part Direct Pay Authorization, shall be filed with the Department of Revenue by the owner of a charter bus qualifying for the repair and replacement part exemption provided under KRS 139.480(32)(b) to apply for a charter bus direct pay authorization.

(39) Revenue Form 51A164, Charter Bus Direct Pay Authorization, shall be issued by the Department of Revenue to authorize charter bus carriers to report and pay directly to the Department the sales and use tax on all purchases of repair and replacement parts for charter buses, and to authorize retailers to sell charter bus repair and replacement parts directly to the charter bus carriers without receipt of sales and use tax.

(40) Revenue Form 51A200, Application for Kentucky Enterprise Initiative Act (KEIA) Tax Refund Program, shall be used by qualified businesses to apply for a refund of sales and use tax paid on purchases of materials used in an approved project.

(41) Revenue Form 51A205, Kentucky Sales and Use Tax Instructions, shall be used by Kentucky sales and use tax permit holders as a guide in filing their sales and use tax returns and maintaining permit account information.

(42) Revenue Form 51A209, Sales and Use Tax Refund Application, shall be completed by a Kentucky sales and use tax permit holder and submitted to the Department of Revenue within four (4) years from the date the tax was paid to apply for a refund of sales and use tax previously paid by the permit holder.

(43) Revenue Form 51A216, Application for Pollution Control Tax Exemption Certificate, shall be completed by a business, governmental unit or institution to apply for a sales and use tax exemption on purchases of tangible personal property used to control or abate pollution.

(44) Revenue Form 51A222, Certificate of Exemption for Alcohol Production Facilities, shall be presented to a retailer by a holder of an alcohol production tax exemption certificate or jointly by a contractor and the holder of an alcohol production tax exemption certificate to claim exemption from sales and use tax on materials and equipment that will become a part of an alcohol production facility as provided by KRS Chapter 247.

(45) Revenue Form 51A223, Application for Alcohol Production Facility Tax Exemption Certificate, shall be completed by a business seeking exemption from sales and use tax on the purchase of materials and equipment that will become a part of an alcohol production facility as provided by KRS Chapter 247.

(46) Revenue Form 51A226, Pollution Control Tax Exemption Certificate, shall be issued by the Department of Revenue to a business who has qualified for certain sales and use tax, corporation income, corporation license, and property tax benefits.

(47) Revenue Form 51A227, Certificate of Resale (Schools), shall be issued to a retailer by an exempt nonprofit elementary or secondary school or the organizations they sponsor or that are affiliated with them to claim an exemption from sales and use tax on the purchase of tangible personal property or digital property that will be resold if the proceeds from the resale of the property is used solely for the benefit of the elementary or secondary schools or their students.

(48) Revenue Form 51A228, Application for Fluidized Bed Combustion Technology Tax Exemption Certificate, shall be completed by a business, governmental unit or organization and submitted to the Department of Revenue to apply for a sales and use tax exemption on the purchase of equipment and materials used in fluidized bed combustion technology.

(49) Revenue Form 51A229, Fluidized Bed Combustion Technology Tax Exemption Certificate, shall be issued by the Department of Revenue to a business, governmental unit or organization to advise that they qualify for corporation license tax, property tax, and sales and use tax benefits.

(50) Revenue Form 51A241, Registration for the Kentucky Sales and Use Tax Refund for Motion Picture and Television Production Companies, shall be completed by a motion picture production company and submitted to the Department of Revenue to register for a sales and use tax refund.

(51) Revenue Form 51A242, Application for Sales and Use Tax Refund for Motion Picture Production Company, shall be completed by a registered motion picture production company and submitted to the Department of Revenue within sixty (60) days after completion of the filming or production of the motion picture in Kentucky to request a refund of the Kentucky sales and use tax paid on purchases of tangible personal property or digital property made in connection with filming and producing motion pictures in Kentucky.

(52) Revenue Form 51A250, Application for Transient Merchant Permit, shall be completed by a transient merchant and filed with the clerk in the county in which the business is to be conducted, or if an urban county government, with the officer of the government who has responsibility for the issuance of business permits and licenses to obtain a permit before conducting any business in Kentucky.

(53) Revenue Form 51A260, Streamlined Sales and Use Tax Agreement-Certificate of Exemption, shall be presented to a seller by a purchaser to claim that tangible personal property, digital property, or certain services purchased from the seller qualifies for exemption.

(54) Revenue Form 51A270, Certificate of Sales Tax Paid on the Purchase of a Motor Vehicle, shall be issued by motor vehicle dealers to a non-resident purchaser of a motor vehicle on which the Kentucky sales tax has been paid.

(55) Revenue Form 51A280, Out-Of-State Purchase-Use Tax Affidavit, shall be submitted to the county clerk by a taxpayer purchasing tangible personal property from out-of-state for title or first-time registration.

(56) Revenue Form 51A290, Information Sharing and Assignment Agreement for Designated Refund Claims, shall be submitted by an approved company or agency and its vendors and contractors who agree to share documentation with the Department of Revenue for refund claim under the Kentucky Enterprise Initiative Act, Signature Project, or Alternative Fuel, Gasification or Renewable Energy Facility.

(57) Revenue Form 51A291, Application for Kentucky Signature Project Sales and Use Tax Refund, shall be completed by an approved company or agency in the construction of an approved Signature Project submitted to the Department of Revenue annually during the twelve (12) years the project grant agreement is in effect.

(58) Revenue Form 51A292, Expenditure Report for Signature Project Refunds, shall be submitted by a refund applicant to document expenditures and taxes paid on property and materials used in the construction of an approved Signature Project.

(59) Revenue Form 51A300, Application for Preapproval for Energy Efficiency Machinery or Equipment, shall be submitted by a person engaged in manufacturing for preapproval for purchase of new or replacement machinery or equipment that reduces the consumption of energy or energy producing fuels by at least fifteen (15) percent.

(60) Revenue Form 51A301, Application for Kentucky Alternative Fuel, Gasification, and Renewable Energy Facility Sales and Use Tax Refund, shall be submitted by a refund applicant to request refund of sales and use tax paid on purchases of building and construction materials purchased and used in the construction of an approved Alternative Fuel, Gasification, or Renewable Facility.

(61) Revenue Form 51A302, Expenditure Report for Alternative Fuel, Gasification, & Renewable Energy Facility Refunds, shall be submitted by a refund applicant to document expenditures and taxes paid on property and materials used in the construction of an approved Alternative Fuel, Gasification, or Renewable Energy Facility.

(62) Revenue Form 51A350, Information Sharing and Assignment Agreement for Energy Efficiency Project Incentive, shall be submitted by an approved company or agency and its

vendors and contractors who agree to share documentation with the Department of Revenue for refund claims on construction of an approved Alternative Fuel, Gasification, or Renewable Energy Facility.

(63) Revenue Form 51A351, Application for Energy Efficiency Machinery or Equipment Sales and Use Tax Incentive, shall be submitted by a refund applicant to request refund of sales and use tax paid on purchases of approved energy-efficiency machinery or equipment used at a manufacturing plant.

(64) Revenue Form 51A400, Governmental Public Facility Sales Tax Rebate Registration, shall be completed by the public facility to determine eligibility for the sales tax rebate under KRS 139.533.

(65) Revenue Form 51A401, Governmental Public Facility Application for Sales Tax Rebate, shall be completed by the public facility to request a sales tax rebate. It includes a list of vendors and tax amounts claimed in the rebate request as well as banking information if an electronic fund transfer is requested by the public facility.

(66) Revenue Form 51A402, Vendor Assignment Agreement for Sales at a Qualifying Public Facility, shall be properly executed for any seller, other than the qualifying governmental entity whose receipts are included in the rebate request.

(67) Revenue Form 51A600, Application for Kentucky Disaster Relief, Sales and Use Tax Refund, shall be completed by the legal building owner to request a sales and use tax refund.

(68) Revenue Form 51A601, Information Sharing and Assignment Agreement for Disaster Relief Refund Claims, shall be completed by the legal building owner and other related parties to ensure compliance with taxpayer confidentiality laws (KRS 131.190, 131.081(15), 131.990).

(69) Revenue Form 51A602, Expenditure Report for Building Materials Disaster Relief Funds, shall be completed by the legal building owner detailing all building materials purchased to repair or replace a building in a disaster area and the total corresponding Kentucky sales and use tax paid and submitted to the Department of Revenue.

(70) Revenue Form 51F008, Federal Government Exemption from Kentucky Sales and Use Tax, shall be issued by the Department of Revenue to a federal government unit which in turn is presented to a retailer by the federal government unit to claim exemption from sales and use tax on purchases of property to be used in the exempt governmental function.

(71)[(68)] Revenue Form 51F009, Purchase Exemption Notification, shall be issued by the Department of Revenue to a resident nonprofit charitable, educational or religious institution to advise the entity of the assigned purchase exemption number and additional information concerning the exemption from sales and use tax.

(72)[(69)] Revenue Form 51F010, Energy Direct Pay Authorization, shall be issued by the Department of Revenue to advise a Kentucky sales and use tax permit holder that it has been authorized to purchase energy and energy-producing fuels without paying or reimbursing the vendor for the sales and use tax and that they are required to report and pay directly to the Department of Revenue the sales and use tax on that portion of the cost price which is subject to tax pursuant to KRS 139.480(3).

(73)[(70)] Revenue Form 51F010(a), Utility Gross Receipts License Tax (UGRLT) Exemption Authorization, shall be issued by the Department of Revenue to advise a Kentucky sales and use tax permit holder that it has been authorized to purchase energy and energy-producing fuels without paying or reimbursing the vendor for the utility gross receipts license tax and that they are required to report and pay directly to the Department of Revenue the utility gross receipts license tax on that portion of the purchase price which is subject to tax.

(74)[(71)] Revenue Form 51F010(b), Energy Direct Pay - Utility Gross Receipts License Tax Exemption Authorization, shall be issued by the Department of Revenue to advise a Kentucky sales and use tax permit holder that it has been authorized to purchase energy and energy-producing fuels without paying or reimbursing the vendor for either the sales and use tax or the utility gross receipts license tax and that they are required to report and pay

directly to the Department of Revenue the sales and use tax and the utility gross receipts license tax on that portion of the purchase price which is subject to tax.

Section 2. Telecommunications Provider Tax - Required Forms. (1) Revenue Form 75A001, Telecommunications Tax Receipts Certification Form, shall be used by city and county taxing jurisdictions to certify tax receipts for prior fiscal year if applicable.

(2) Revenue Form 75A002, Telecommunications Provider Tax Return, shall be used by telecommunications providers to report gross revenues subject to the excise tax and gross revenues tax, and by consumers to report retail purchases of multi-channel video programming services to report the tax due.

(3) Revenue Form 75A002 (I), Instructions for Telecommunications Provider Tax Return, shall be used by telecommunications providers as a guide in filing their telecommunications provider tax return.

(4) Revenue Form 75A005, Telecommunications Tax Complaint Form, shall be submitted to the Department of Revenue by local taxing authorities who express disagreement with the distribution of telecommunications tax to their jurisdiction.

(5) Revenue Form 75A900, Telecommunications Tax Application, shall be used by telecommunications providers to register with the Department of Revenue.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

- (a) Sales and use tax - referenced material:
 1. Revenue Form 51A101(a), "Sales and Use Tax Permit", August 2011;
 2. Revenue Form 51A101(b), "Sales and Use Tax Permit Update", August 2011;
 3. Revenue Form 51A101(c)(1), "Kentucky Streamlined Sales and Use Tax (SST) Filing Permit", August 2008;
 4. Revenue Form 51A101(c)(2), "Kentucky Streamlined Sales and Use Tax (SST) Filing Permit", August 2008;
 5. Revenue Form 51A101(c)(4), "Kentucky Streamlined Sales and Use Tax (SST) Filing Permit", August 2008;
 6. Revenue Form 51A101(d), "Sales and Use Tax Permit Update (SST)", August 2011;
 7. Revenue Form 51A102, "Kentucky Sales and Use Tax Worksheet", January 2012[2010];
 8. Revenue Form 51A102E, "Kentucky Sales and Use Tax Worksheet - Electronic Funds Transfer", January 2012[2010];
 9. Revenue Form 51A103, "Kentucky Accelerated Sales and Use Tax Worksheet", January 2012[2010];
 10. Revenue Form 51A103E, "Kentucky Accelerated Sales and Use Tax Worksheet - Electronic Funds Transfer", January 2010;
 11. Revenue Form 51A105, "Resale Certificate", December 2009;
 12. Revenue Form 51A109, "Application for Energy Direct Pay Authorization (Sales and Use Tax and Utility Gross Receipts License Tax)", February 2011;
 13. Revenue Form 51A110, "Direct Pay Authorization", April 2011;
 14. Revenue Form 51A111, "Certificate of Exemption Machinery for New and Expanded Industry", August 2011;
 15. Revenue Form 51A112, "Application for Direct Pay Authorization", December 2009;
 16. Revenue Form 51A113, "Kentucky Consumer's Use Tax Worksheet", January 2010;
 17. Revenue Form 51A113(O), "Consumer's Use Tax Return", December 2009;
 18. Revenue Form 51A115, "Order for Selected Sales and Use Tax Publications", April 2011;
 19. Revenue Form 51A116, "Use Tax Compliance Inquiry Worksheet", March 2008;
 20. Revenue Form 51A125, "Application for Purchase Exemption Sales and Use Tax", December 2009;
 21. Revenue Form 51A126, "Purchase Exemption Certificate", December 2009;
 22. Revenue Form 51A127, "Out-of-State Purchase Exemption Certificate", December 2009;

23. Revenue Form 51A128, "Solid Waste Recycling Machinery Exemption Certificate", March 2005;

24. Revenue Form 51A129, "Kentucky Sales and Use Tax Energy Exemption Annual Return", February 2011;

25. Revenue Form 51A130, "Kentucky Sales and Use Tax Monthly Aviation Fuel Tax Credit Schedule of Qualified Certificated Air Carriers", August 2005;

26. Revenue Form 51A131, "Kentucky Sales and Use Tax Monthly Aviation Fuel Dealer Supplementary Schedule", August 2008;

27. Revenue Form 51A132, "Kentucky Sales and Use Tax Equine Breeders Supplementary Schedule", June 2005;

28. Revenue Form 51A135, "Kentucky Sales Tax Motor Vehicle Sales Supplementary Schedule", August 2006;

29. Revenue Form 51A143, "Purchase Exemption Certificate - Watercraft Industry", March 2005;

30. Revenue Form 51A149, "Certificate of Exemption for Pollution Control Facilities", January 2007;

31. Revenue Form 51A150, "Aircraft Exemption Certificate", January 2005;

32. Revenue Form 51A154, "Certificate of Exemption Out-of-State Delivery for Aircraft, All Terrain Vehicle (ATV), Mobile/Manufactured Homes, Campers, Boats, Motors or Trailers", January 2005;

33. Revenue Form 51A157, "Certificate of Exemption - Water Used in Raising Equine", July 2005;

34. Revenue Form 51A158, "Farm Exemption Certificate", July 2008;

35. Revenue Form 51A159, "On-Farm Facilities Certificate of Exemption for Materials, Machinery and Equipment", July 2008;

36. Revenue Form 51A160, "Application for Truck Part Direct Pay Authorization", March 2005;

37. Revenue Form 51A161, "Truck Part Direct Pay Authorization", December 2006;

38. Revenue Form 51A163, "Application for Charter Bus Part Direct Pay Authorization", June 2005;

39. Revenue Form 51A164, "Charter Bus Direct Pay Authorization", August 2006;

40. Revenue Form 51A200, "Application for Kentucky Enterprise Initiative Act (KEIA) Tax Refund Program", March 2008;

41. Revenue Form 51A205, "Kentucky Sales and Use Tax Instructions", July 2008;

42. Revenue Form 51A209, "Sales and Use Tax Refund Application", May 2007;

43. Revenue Form 51A216, "Application for Pollution Control Tax Exemption Certificate", March 2005;

44. Revenue Form 51A222, "Certificate of Exemption for Alcohol Production Facilities", August 2011;

45. Revenue Form 51A223, "Application for Alcohol Production Facility Tax Exemption Certificate", July 1980;

46. Revenue Form 51A226, "Pollution Control Tax Exemption Certificate", March 2005;

47. Revenue Form 51A227, "Certificate of Resale (Schools)", May 2007;

48. Revenue Form 51A228, "Application for Fluidized Bed Combustion Technology Tax Exemption Certificate", May 2007;

49. Revenue Form 51A229, "Fluidized Bed Combustion Technology Tax Exemption Certificate", August 2011;

50. Revenue Form 51A241, "Registration for the Kentucky Sales and Use Tax Refund for Motion Picture and Television Production Companies", May 2007;

51. Revenue Form 51A242, "Application for Sales and Use Tax Refund for Motion Picture Production Company", May 2007;

52. Revenue Form 51A250, "Application for Transient Merchant Permit", April, 2005;

53. Revenue Form 51A260, "Streamlined Sales and Use Tax Agreement - Certificate of Exemption", January 2012[February 2010];

54. Revenue Form 51A270, "Certificate of Sales Tax Paid on the Purchase of a Motor Vehicle", August 2006;

55. Revenue Form 51A280, "Out-Of-State Purchase-Use Tax Affidavit", July 2009;

56. Revenue Form 51A290, "Information Sharing and

Assignment Agreement for Designated Refund Claims", October 2007;

57. Revenue Form 51A291, "Application for Kentucky Signature Project Sales and Use Tax Refund", April 2011;

58. Revenue Form 51A292, "Expenditure Report for Signature Project Refunds", October 2007;

59. Revenue Form 51A300, "Application for Preapproval for Energy Efficiency Machinery or Equipment", June 2008;

60. Revenue Form 51A301, "Application for Kentucky Alternative Fuel, Gasification, and Renewable Energy Facility Sales and Use Tax Refund", April 2011;

61. Revenue Form 51A302, "Expenditure Report for Alternative Fuel, Gasification, & Renewable Energy Facility Refunds", December 2008;

62. Revenue Form 51A350, "Information Sharing and Assignment Agreement for Energy Efficiency Project Incentive", June 2008;

63. Revenue Form 51A351, "Application for Energy Efficiency Machinery or Equipment Sales and Use Tax Incentive", April 2011;

64. Revenue Form 51A400, "Governmental Public Facility Sales Tax Rebate Registration", June 2010;

65. Revenue Form 51A401, "Governmental Public Facility Application for Sales Tax Rebate", June 2010;

66. Revenue Form 51A402, "Vendor Assignment Agreement for Sales at a Qualifying Public Facility", June 2010;

67. Revenue Form 51A600, "Application for Kentucky Disaster Relief Sales and Use Tax Refund", April 2012;

68. Revenue Form 51A601, "Information Sharing and Assignment Agreement for Disaster Relief Refund Claims", April 2012;

69. Revenue Form 51A602, "Expenditure Report for Building Materials Disaster Relief Refunds", April 2012;

70. Revenue Form 51F008, "Federal Government Exemption from Kentucky Sales and Use Tax", January 2008;

71[68]. Revenue Form 51F009, "Purchase Exemption Notification", January 2008;

72[69]. Revenue Form 51F010, "Energy Direct Pay Authorization", January 2008;

73[70]. Revenue Form 51F010(a), "Utility Gross Receipts License Tax (UGRLT) Exemption Authorization", January 2008; and

74[71]. Revenue Form 51F010(b), "Energy Direct Pay - Utility Gross Receipts License Tax Exemption Authorization", January 2008;

(b) Telecommunications provider tax - referenced material:

1. Revenue Form 75A001, "Telecommunications Tax Receipts Certification Form", December 2005;

2. Revenue Form 75A002, "Telecommunications Provider Tax Return", March 2006;

3. Revenue Form 75A002(I), "Instructions for Telecommunications Provider Tax Return", July 2006;

4. Revenue Form 75A005, "Telecommunications Tax Complaint Form", April 2011; and

5. Revenue Form 75A900, "Telecommunications Tax Application", December 2005.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40620, or at any Kentucky Department of Revenue Taxpayer Service Center, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 from 10:00 a.m. to 12:00 p.m., in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 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 February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Department of Revenue, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9826, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of Sales and Use Tax and Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order for the Department of Revenue to meet the requirements of KRS 13A.110 which requires that forms required to be submitted by a regulated entity shall be included in an administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of the Sales and Use Tax and the Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation incorporates by reference the required revenue forms used in the administration of the Sales and Use Tax and Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

(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 updated form information.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure that the most recent versions of forms are referenced.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment incorporates the most recent forms by reference as authorized by KRS 131.130(3).

(d) How the amendment will assist in the effective administration of the statutes: This amendment informs taxpayers of the most recent versions of forms that should be used to file their tax returns.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All Kentucky taxpayers and their representatives will be affected by the listing of forms administered by the Department of Revenue in an administrative regulation. Local government will be affected to the extent they utilize forms administered by the Department of Revenue. The Department of Revenue will be affected to the extent that it administers the referenced forms.

(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 will have to be taken by the taxpayers or local governments to comply with 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): There will be no anticipated cost incurred by the taxpayer or local government.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Taxpayers will be able to reference all sales and use and telecommunications excise and gross revenues tax forms in one location.

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

(a) Initially: The Department of Revenue will not incur additional costs as the result of this regulation.

(b) On a continuing basis: The Department of Revenue will not incur additional costs as the result of this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Department of Revenue agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new or by the change if it is an amendment: This administrative regulation does not require an increase in fees or funding.

(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 either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied because the requirements of this regulation apply to every taxpayer.

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 Revenue 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 131.130(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) will for the first full year the administrative regulation is to be in effect. There will be no effect on expenditures or revenue of a state or local government agency as a result of this administrative regulation.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? 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:

STATEMENT OF EMERGENCY
103 KAR 3:030E

This emergency administrative regulation is being promulgated in order to provide Kentucky taxpayers the forms and information necessary to comply with Kentucky tax laws. This administrative regulation must be filed as soon as possible in order to incorporate by reference such tax forms and instructions as may be needed by taxpayers and their representative to comply with Kentucky tax laws. An ordinary administrative regulation is not sufficient, because the public relies on these forms and instructions in order to make timely and accurate filing of tax returns and payment of the correct amount of tax due. This emergency administrative regulation shall be replaced by an ordinary administrative regulation which is being filed with the Regulations Compiler along with this emergency administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
THOMAS B. MILLER, Commissioner

FINANCE AND ADMINISTRATION CABINET
Department of Revenue
Office of Property Valuation
(Emergency Amendment)

103 KAR 3:030E. Property and Severance Forms manual.

RELATES TO: KRS 42.470, 61.870-61.884, 131.020, 131.030, 131.041-131.081, 131.081(2), (9), (15), 131.110, 131.130, 131.130(3), 131.155, 131.181, 131.183, 131.190, 131.340, 131.500, 131.500(1), (2), (3), (10), 131.510(1), (2)(a), 131.540, 132.020, 132.130-132.180, 132.190, 132.200, 132.220-132.270, 132.290, 132.310, 132.320, 132.360, 132.450, 132.487, 132.510, 132.820, 132.825, 132.990, 133.045, 133.110, 133.120, 133.130, 133.240, 134.015, 134.119, 134.020, 134.121, 134.122, 134.128, 134.129, 134.390, 134.420, 134.430, 134.440, 134.500, 134.590, 134.800, 134.805, 134.810, 134.815, 134.820, 134.825, 134.830, 135.010, 135.020, 135.050, 136.020, 136.050, 136.115-136.180, 136.1802-136.1806, 136.1873, 136.188, 136.310, 136.320, 136.330, 136.335, 136.377, 136.545, 136.575, 136.600-136.660, 137.130, 137.160, 143.030(1), 143.037, 143.040, 143.050, 143.060(1), 143.085, 143.990, 143A.010, 143A.030, 143A.035, 143A.037, 143A.080, 143A.090, 143A.100(1), 143A.991, Ky. Const. Sec. 170

STATUTORY AUTHORITY: KRS 131.130(3)

EFFECTIVE: December 27, 2013

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue Forms used in the administration of Property and Severance Taxes by the Department of Revenue.

Section 1. Property Tax - Required Forms. (1) Revenue Form 61A200(P), "Property Tax Forms and Instructions for Public Service Companies 2014[2013]", shall be the packet of files and instructions relating to Revenue Form 61A200 for use by public service companies reporting company name, location and other pertinent filing information with the Department of Revenue.

(2) Revenue Form 61A200, "Public Service Company Property Tax Return for Year Ending December 31, 2013[2012]", shall be filed by public service companies reporting company name, location, and other pertinent filing information with the Department of Revenue.

(3) Revenue Form 61A200(A), "Report of Total Unit System and Kentucky Operations", shall be filed by public service companies with the Department of Revenue, reporting the System and Kentucky original cost, total depreciation and depreciated cost for all operating and non-operating property types as of the end of the taxable year.

(4) Revenue Form 61A200(B), "Report of Kentucky Vehicles, Car Lines and Watercraft", shall be filed by public service companies with the Department of Revenue, reporting the assessed value of all Kentucky apportioned and regular licensed motor vehicles, railroad car lines and commercial watercraft as of the end of the year.

(5) Revenue Form 61A200(C), "Report of Total Unit Operations Balance Sheet", shall be filed by public service companies with the Department of Revenue, reporting a financial statement (balance sheet) as of December 31 for the system operating unit including Kentucky.

(6) Revenue Form 61A200(D), "Report of Total Unit Operations Income Statement", shall be filed by public service companies with the Department of Revenue, reporting a financial statement (income statement) for twelve (12) months ending December 31 for the system operating unit including Kentucky.

(7) Revenue Form 61A200(E), "Filing Extension Application", shall be used by public service companies to request an extension of time to file the public service company tax return.

(8) Revenue Form 61A200(G), "Report of Capital Stocks", shall be filed by public service companies with the Department of Revenue, reporting an analysis of their capital stocks as of the end of the taxable year.

(9) Revenue Form 61A200(H), "Report of Funded Debt", shall be filed by public service companies with the Department of Revenue reporting an analysis of their debt as of the end of the taxable year.

(10) Revenue Form 61A200(I), "Business Summary by Taxing Jurisdiction", shall be filed by public service companies with the Department of Revenue, reporting a summary of the business activity within each taxing district.

(11) Revenue Form 61A200(J), "Property Summary by Taxing Jurisdiction, Operating and Nonoperating Property", shall be filed by public service companies with the Department of Revenue reporting a summary of the amount of operating and nonoperating property owned or leased in this state, by each county, city and special district.

(12) Revenue Form 61A200(K), "Operating Property Listing by Taxing Jurisdiction", shall be filed by public service companies with the Department of Revenue, reporting an inventory of the amount and kind of operating property, owned or leased, located in this state, for each county, city and special taxing district.

(13) Revenue Form 61A200(K2), "Nonoperating/Nonutility Property Listing by Taxing Jurisdiction", shall be filed by public service companies with the Department of Revenue reporting an inventory of the amount and kind of nonoperating property owned or leased, located in this state, for each county, city and special taxing district.

(14) Revenue Form 61A200(L), "Report of Allocation Factors, Operating and Noncarrier Property for All Interstate Companies", shall be filed by interstate, noncarrier, public service companies with the Department of Revenue, reporting property and business factors in total and for the state of Kentucky.

(15) Revenue Form 61A200(M), "Report of Property and Business Factors for Interstate Railroad and Sleeping Car Companies", shall be filed by interstate railroad and sleeping car companies with the Department of Revenue, reporting property and business factors in total and for the state of Kentucky.

(16) Revenue Form 61A200(N1), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", shall be filed by public service companies with the Department of Revenue, reporting all leased real property and the terms of the lease by taxing district.

(17) Revenue Form 61A200(N2), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", shall be filed by public service companies with the Department of Revenue, reporting all leased personal property and the terms of the lease by taxing district.

(18) Revenue Form 61A200(N3), "Summary Report of System and Kentucky Operating Lease Payments", shall be filed by public service companies with the Department of Revenue reporting the annual operating lease payments paid during the calendar year.

(19) Revenue Form 61A200(O), "Railroad Private Car Mileage

Report", shall be filed by railroad car line companies with the Department of Revenue reporting the name and address of the company and the mileage in Kentucky.

(20) Revenue Form 61A200(Q), "Supplemental Report of Operations for Contained and Residential Landfills", shall be filed by landfills with the Department of Revenue, reporting historic, current, and projected operational information.

(21) Revenue Form 61A200(R), "Report of Property Subject to the Pollution Control Tax Exemption", shall be filed by public service companies with the Department of Revenue, reporting certified pollution control equipment, the original cost and the net book value.

(22) Revenue Form 61A200(U), "Industrial Revenue Bond Property", shall be filed by a public service company to list real and tangible personal property purchased with an industrial revenue bond.

(23) Revenue Form 61A202, "2014[2013] Public Service Company Property Tax Return for Railroad Car Line", shall be filed by railroad car line companies with the Department of Revenue, classifying the railcars by type and reporting cost, age, and mileage for each railcar.

(24) Revenue Form 61A206(P), "Public Service Company Property Tax Forms and Instructions for Commercial Air Passenger and Air Freight Carriers 2014[2013]", shall be the packet of files and instructions relating to Revenue Form 61A206 for use by commercial air passenger and air freight carriers reporting company name, location and other pertinent information with the Department of Revenue.

(25) Revenue Form 61A206, "Public Service Company Property Tax Return For Commercial Air Passenger and Air Freight Carriers", shall be filed by all commercial air passenger and air freight carriers reporting taxpayer name, location and other pertinent information with the Department of Revenue.

(26) Revenue Form 61A206(A), "Filing Extension Application for Public Service Company Property Tax Return", shall be used by commercial air passenger and air freight carriers to request an extension of time to file the commercial air passenger and air freight carriers tax return.

(27) Revenue Form 61A206(B), "Report of Kentucky Registered and Licensed Motor Vehicles", shall be filed by commercial air passenger and air freight carriers to report vehicles, both owned and leased, registered within the state of Kentucky as of December 31.

(28) Revenue Form 61A206(C), "Report of Financial Operations for Commercial Air Passenger and Air Freight Carriers", shall be used by all commercial, passenger or cargo airlines conducting business in Kentucky to provide the Department of Revenue with year-end financial statements, a complete annual report, and a complete 10K report (FCC annual report) for the twelve (12) month period ending December 31.

(29) Revenue Form 61A206(D-1), "Report of System Aircraft Fleet", shall be filed by commercial air passenger and air freight carriers providing a complete listing of fleet aircraft owned and capital-leased as of December 31.

(30) Revenue Form 61A206(D-2), "Report of System Aircraft Fleet", shall be filed by commercial air passenger and air freight carriers providing a complete listing of operating leased fleet aircraft.

(31) Revenue Form 61A206(D-3), "Report of System Aircraft Fleet", shall be filed by all commercial air passenger and air freight carriers providing a complete listing of all fleet managed aircraft and aircraft held for resale or nonoperating.

(32) Revenue Form 61A206(E), "Report of Kentucky Flight Statistics By Airport", shall be filed by all commercial air passenger and air freight carriers providing a listing of all arrivals, departures, and ground time at all Kentucky airports and heliports.

(33) Revenue Form 61A206(F), "Report of System and Kentucky Allocation Factors", shall be filed by all commercial air passenger and air freight carriers listing property factors and business factors.

(34) Revenue Form 61A206(G), "Report of Funded Debt", shall be filed by all commercial air passenger and air freight carriers listing all debt obligations, both long term and short term, by class

and obligation.

(35) Revenue Form 61A206(H), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing all real property in Kentucky leased on an operating lease basis.

(36) Revenue Form 61A206(I), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing all personal property in Kentucky leased on an operating lease basis.

(37) Revenue Form 61A206(J), "Summary Report of System and Kentucky Operating Lease Payments", shall be filed by all commercial air passenger and air freight carriers listing all annual operating lease payments.

(38) Revenue Form 61A206(K), "Report of Owned Real Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing all real property owned in Kentucky.

(39) Revenue Form 61A206(L), "Report of Owned Personal Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing all personal property owned in Kentucky.

(40) Revenue Form 61A206(M), "Summary Report of Total System and Kentucky Operations", shall be filed by all commercial air passenger and air freight carriers listing all real and personal property owned and leased, providing the original cost, depreciation and depreciated cost values.

(41) Revenue Form 61A206(N), "Industrial Revenue Bond Property", shall be filed by all commercial air passenger and air freight carriers listing real and tangible property purchased with an industrial revenue bond.

(42) Revenue Form 61A206(O), "Public Service Company Sales", shall be filed by commercial air passenger and air freight carriers listing any assets bought or sold during the year.

(43) Revenue Form 61A207(P), "Commercial Watercraft Personal Property Tax Return 2014[2013]", shall be the packet of files and instructions relating to Revenue Form 61A207 for use by commercial watercraft owners both resident and nonresident, reporting the watercraft's book value, original cost and total and Kentucky route mileage with the Department of Revenue.

(44) Revenue Form 61A207, "2014[2013] Commercial Watercraft Personal Property Tax Return", shall be filed by all commercial watercraft owners, both resident and nonresident, reporting the watercraft's book value, original cost, and total and Kentucky route mileage with the Department of Revenue.

(45) Revenue Form 61A207(A), "Report of Owned Vessels in Your Possession", shall be filed with the Department of Revenue, reporting all owned vessels (both available and operating) in their fleet as of January 1, 2014[2013].

(46) Revenue Form 61A207(B), "Report of Owned Vessels - in Possession of Others", shall be filed with the Department of Revenue, reporting all owned vessels that are in possession of other persons, companies, corporations, operators, or charterers as of January 1, 2014[2013].

(47) Revenue Form 61A207(C), "Report of Nonowned Vessels in Your Possession", shall be filed with the Department of Revenue, reporting all nonowned vessels (both available and operating) in their fleet as of January 1, 2014[2013].

(48) Revenue Form 61A207(D), "Commercial Watercraft Valuation Worksheet", shall be filed with the Department of Revenue, reporting the original cost, cost of rebuilds and the cost of major improvements of all owned and nonowned vessels.

(49) Revenue Form 61A207(E), "Report of Kentucky Route Miles", shall be filed with the Department of Revenue reporting the system route miles traveled on Kentucky waterways.

(50) Revenue Form 61A207(F), "Report of System Route Miles", shall be filed with the Department of Revenue reporting the system route miles traveled on United States waterways.

(51) Revenue Form 61A209, "Public Service Company Sales", shall be filed by public service companies with the Department of Revenue, reporting any full or partial sale or purchase of assets of the public service company.

(52) Revenue Form 61A211, "Public Service Company

Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs", shall be filed by public service companies with the Department of Revenue reporting all motor vehicles owned or leased within Kentucky.

(53) Revenue Form 61A211(I), "Instructions Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs", shall provide instructions for completing Revenue Form 61A211, "Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs".

(54) Revenue Form 61A211(IP), "Instructions For Editing the Public Service Company Motor Vehicle Printout", shall provide instructions for editing the computer printout of previously reported licensed vehicles sent by the Department of Revenue to public service companies that have listed vehicles with the department in prior years.

(55) Revenue Form 61A230, "Notice of Assessment", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the final assessment of the public service company property.

(56)[(65)] Revenue Form 61A240, "Notice of Assessment", shall be sent by the Department of Revenue to the taxpayer notifying him or her of a tentative assessment of the public service company property. This notice shall inform the taxpayer of the protest period.

(57)[(66)] Revenue Form 61A250, "Notice of Assessment", shall be sent by the Department of Revenue to the taxpayer notifying the taxpayer of his or her claim of assessed value on public service company property.

(58)[(67)] Revenue Form 61A255, "Public Service Company Property Tax Statement", shall be used by the counties, schools and special districts to bill public service companies for local property taxes.

(59)[(68)] Revenue Form 61A255(I), "Instructions for 61A255, Public Service Company Property Tax Statement", shall provide instructions for completing Revenue Form 61A255, "Public Service Company Property Tax Statement".

(60)[(69)] Revenue Form 61A500(P), "2014[2013] Personal Property Tax Forms and Instructions for Communications Service Providers and Multichannel Video Programming Service Providers", shall be the packet of files and instructions relating to Revenue Form 61A500 for use by telecommunication, satellite, and cable television companies, reporting all tangible personal property with the Department of Revenue.

(61)[(70)] Revenue Form 61A500, "2014[2013] Tangible Personal Property Tax Return for Communications Service Providers and Multichannel Video Programming Service Providers", shall be filed by telecommunications, satellite, and cable television companies, reporting all tangible personal property with the Department of Revenue.

(62)[(71)] Revenue Form 61A500(H), "Report of Total Personal Tangible Property in Kentucky", shall be filed by telecommunication, satellite, and cable television companies with the Department of Revenue, summarizing the Kentucky original cost, depreciation, and net book value of each class of tangible personal property.

(63)[(72)] Revenue Form 61A500(I), "Summary of Gross Personal Tangible Property Listing by Taxing District", shall be filed by telecommunication, satellite, and cable television companies with the Department of Revenue, summarizing the Kentucky Original Cost by taxing jurisdiction.

(64)[(73)] Revenue Form 61A500(J), "Summary of Reported Personal Tangible Property Listing by Taxing District", shall be filed by telecommunication, satellite, and cable television companies with the Department of Revenue, summarizing the Kentucky reported value by taxing jurisdiction.

(65)[(74)] Revenue Form 61A500(K), "Personal Tangible Property Listing by Taxing District", shall be filed by telecommunication, satellite and cable television companies with the Department of Revenue and shall contain an inventory of the amount and kind of personal property owned and located in Kentucky by taxing jurisdiction.

(66)[(75)] Revenue Form 61A508, "Annual Report of Distilled Spirits in Bonded Warehouse", shall be filed by distilleries with the Department of Revenue to report inventory as of January 1.

(67)[(66)] Revenue Form 61A508-S1, "Schedule 1 Department of Property Valuation Cost of Production Schedule", shall be filed by distilleries with the Department of Revenue, reporting the average cost per gallon of production.

(68)[(67)] Revenue Form 61A508-S2, "Schedule 2 Department of Property Valuation Storage Cost Schedule", shall be filed by distilleries with the Department of Revenue, reporting average per barrel storage cost.

(69)[(68)] Revenue Form 61A508-S3, "Schedule 3 Schedule of Bulk Sales", shall be filed by distilleries with the Department of Revenue, reporting the date of the sale or purchase, the number of barrels, age, and the price.

(70)[(69)] Revenue Form 61A508-S4, "Schedule 4", shall be filed by distilleries with the Department of Revenue, reporting the fair cash value of bulk inventory summarized on Form 61A508.

(71)[(70)] Revenue Form 61A508-S5, "Schedule 5", shall be filed by distilleries with the Department of Revenue, reporting the fair cash values of case goods summarized on Form 61A508.

(72) Revenue Form 61A508-S6, "Schedule 6 Industrial Revenue Bond Property", shall be filed with the Department of Revenue, reporting property purchased with an industrial revenue bond.

(73)[(71)] Revenue Form 61A509, "Distilled Spirits or Telecoms Property Tax Statement", shall be used by county clerks and local tax jurisdictions to bill assessments of distilled spirits and telecom personal property.

(74)[(72)] Revenue Form 61F007, "Notification Protesting Your Commercial Watercraft Assessment", shall inform taxpayers of the protest procedures on Commercial Watercraft assessments.

(75)[(73)] Revenue Form 61F008, "Notification Protesting Your Assessment", shall inform taxpayers of the protest procedures on Railroad Car Line assessments.

(76)[(74)] Revenue Form 61F009, "Notification Protesting Your Assessment", shall inform taxpayers of the protest procedures on Public Service Company Property Tax assessments.

(77)[(75)] Revenue Form 61F010, "Property Value Assessments for Public Service and Centrally Assessed Companies - Assessment of Distilled Spirits in Bonded Warehouses", shall inform taxpayers of the protest procedures on Distilled Spirits assessments.

(78)[(76)] Revenue Form 62A007, "Motor Vehicle Tax and/or Registration Renewal Notice", shall be issued by the Department of Revenue to notify motor vehicle owners of their ad valorem property tax liabilities and registration renewal deadline.

(79)[(77)] Revenue Form 62A007S, "Motor Vehicle/Boat Property Tax Notice - Second Notice", shall be issued by the Department of Revenue to notify motor vehicle and boat owners of their delinquent ad valorem property tax liabilities.

(80)[(78)] Revenue Form 62A008, "Motor Vehicle Tax Notice", shall be issued by the Department of Revenue to notify motor vehicle owners of their ad valorem property tax liabilities.

(81)[(79)] Revenue Form 62A009, "Map Sales Invoice", shall be provided to the customer by the Department of Revenue as a receipt for payment of maps purchased.

(82)[(80)] Revenue Form 62A010, "Notice for Boat Transfer", shall be issued to January 1 owners of boats transferred during the calendar year informing them of the ad valorem tax due on the transferred boat.

(83)[(81)] Revenue Form 62A013, "Application for Assessment Moratorium Certificate", shall be filed by property owners seeking an assessment moratorium on qualifying existing property undergoing repair, rehabilitation or restoration. The form shall be filed with the proper administrating agency of the county in which the property is located, thirty (30) days prior to restoration or repair.

(84)[(82)] Revenue Form 62A015, "2014[2013] Motor Vehicle and Watercraft Property Tax Rate Certification", shall be submitted annually to the Department of Revenue by motor vehicle and watercraft taxing jurisdictions to certify the rates established by the taxing jurisdiction for motor vehicles and watercraft.

(85)[(83)] Revenue Form 62A016, "Quietus", shall be issued by the Department of Revenue to certify that a county clerk is in good standing with regard to the conduct of ad valorem property tax collection duties.

~~(86)~~~~(84)~~ Revenue Form 62A017, "County Clerk's Claim for Calculation of Motor Vehicle and Boat Bills", shall be completed by the Department of Revenue and county clerk to certify the total number of motor vehicle and boat accounts for a given county and determine the county clerk's compensation for making tax bills.

~~(87)~~~~(85)~~ Revenue Form 62A020, "Intercounty Property Tax Collections", shall be completed by the Department of Revenue to list distributions of ad valorem property tax made to individual taxing jurisdictions.

~~(88)~~~~(86)~~ Revenue Form 62A023, "Application for Exemption from Property Taxation", shall be filed by organizations seeking a property tax exemption under Ky. Const. Sec. 170. This form shall be filed with the property valuation administrator of the county in which the property is located.

~~(89)~~~~(87)~~ Revenue Form 62A030, "Request for Reproduction of PVA Public Records and Contract for Commercial Users", shall be submitted to request copies of documents required to be retained by the PVA.

~~(90)~~~~(88)~~ Revenue Form 62A044, "Affidavit for Correction/Exoneration of Motor Vehicle/Boat/Trailer Property Tax", shall be completed by the owner of a vehicle, boat, or trailer at the property valuation administrator's office in order to correct owner or vehicle, boat, or trailer information in the ad valorem tax computer system. The PVA shall present the form to the county clerk when a tax refund is authorized.

~~(91)~~~~(89)~~ Revenue Form 62A200(P), "2014[2013] Unmined Coal Property Tax Information Return", shall be the packet of files and instructions relating to Revenue Form 62A200 for use by owners or lessees of unmined minerals, reporting filer information with the Department of Revenue.

~~(92)~~~~(90)~~ Revenue Form 62A200, "2014[2013] Unmined Coal Property Tax Information Return", shall be filed by owners or lessees of unmined minerals, reporting filer information with the Department of Revenue.

~~(93)~~~~(91)~~ Revenue Form 62A200, "Schedule A Fee Property Ownership", shall be filed by owners or lessees of unmined minerals with the Department of Revenue, reporting ownership information for each parcel or royalty information for each leased parcel.

~~(94)~~~~(92)~~ Revenue Form 62A200, "Schedule B Leased Property", shall be filed by all lessees and sublessees with the Department of Revenue, reporting ownership information for each parcel or royalty information for each leased parcel.

~~(95)~~~~(93)~~ Revenue Form 62A200, "Schedule C Property or Stock Transfers", shall be filed by both purchasers and sellers of unmined mineral property, with the Department of Revenue, reporting details of the transaction.

~~(96)~~~~(94)~~ Revenue Form 62A200, "Schedule D Lease Terminations, Transfers or Assignments", shall be filed by lessors or lessees of unmined minerals, with the Department of Revenue, reporting the parcel number, the date the lease was terminated and the seams assigned.

~~(97)~~~~(95)~~ Revenue Form 62A200, "Schedule E Farm Exception to Unmined Minerals Tax", shall be filed by surface owners, who own the mineral rights in their entirety and are engaged primarily in farming, to be excepted from the unmined minerals tax.

~~(98)~~~~(96)~~ Revenue Form 62A200, "Schedule F Geological Information by County", shall be filed by owners or lessees of unmined minerals, with the Department of Revenue, reporting exploration and analytical information.

~~(99)~~~~(97)~~ Revenue Form 62A301-S, "Omitted Real Estate Property Tax Bill" shall be used by the sheriff to inform taxpayers of an omitted real estate property tax liability.

~~(100)~~~~(98)~~ Revenue Form 62A302, "Request for Information for Local Board of Tax Appeals", shall be filed by taxpayers with the property valuation administrator, if appealing their assessment on real property.

~~(101)~~~~(99)~~ Revenue Form 62A304, "Property Valuation Administrator's Recapitulation of Real Property Tax Roll", shall be filed by the property valuation administrator by the first Monday in April, showing a recapitulation of property assessments by type of property and by taxing district. This form shall also be known as

"first recap".

~~(102)~~~~(100)~~ Revenue Form 62A305, "Property Valuation Administrator's Summary of Real Property Tax Roll Changes (Since Recapitulation)", shall be filed by the property valuation administrator within six (6) days of the conclusion of the real property tax roll inspection period, showing all changes made since the submission of Revenue Form 62A304. This form shall also be known as "final recap" or "second recap".

~~(103)~~~~(101)~~ Revenue Form 62A307, "Property Owner Conference Record", shall be used by the property valuation administrator to document a property owner's appeal conference. The property owner or his or her representative shall be asked to sign the record and shall be given a copy of the record.

~~(104)~~~~(102)~~ Revenue Form 62A323, "Record of Additions and Deletions", shall be used by the PVA to report all real property additions and deletions for a particular assessment year.

~~(105)~~~~(103)~~ Revenue Form 62A329, "Annual Report of Domestic Life Insurance Companies", shall be filed by life insurance companies doing business in Kentucky, with the Department of Revenue, reporting the fair cash value of the company's intangible property, both taxable and exempt, and the aggregate amount.

~~(106)~~~~(104)~~ Revenue Form 62A350, "Application for Exemption Under the Homestead/Disability Amendment", shall be filed by property owners seeking an exemption from property taxes under Ky. Const. Sec. 170. This application shall be filed with the property valuation administrator of the county in which the residential unit is located.

~~(107)~~~~(105)~~ Revenue Form 62A352, "Notice to Real Property Owner of Assessment by Property Valuation Administrator", shall be mailed to the property owner by the property valuation administrator notifying him or her of the assessment amount and of his or her appeal rights.

~~(108)~~~~(106)~~ Revenue Form 62A353, "Notice of Listing of Omitted Real Property", shall be mailed by the property valuation administrator to the property owner. This document shall notify the property owner that his or her omitted property has been listed and assessed and of his or her appeal rights.

~~(109)~~~~(107)~~ Revenue Form 62A354, "Notice to Property Owner of Final Decision of Board of Assessment Appeals", shall be sent from the Board of Assessment Appeals to the property owner to inform him or her of its ruling.

~~(110)~~~~(108)~~ Revenue Form 62A358, "Receipt for Transferring Delinquent Property Tax Bills From the Sheriff to the County Clerk", shall be signed by both the sheriff and county clerk to affirm the number and total amount of delinquent tax bills transferred from the sheriff to the county clerk.

~~(111)~~~~(109)~~ Revenue Form 62A358-S, "Supplemental Receipt to Document Timely Postmarked Payments Received After the Delinquent Tax Bill Transfer Date", shall be signed by both the sheriff and the county clerk to affirm payments received by the sheriff via mail and postmarked timely after the transfer date.

~~(112)~~~~(110)~~ Revenue Form 62A359, "Sheriff's Report of Real Property Tax Bills Transferred to the County Clerk", shall be used by the sheriffs to report delinquent real estate tax bills that were transferred from the sheriff to the county clerk's office.

~~(113)~~~~(111)~~ Revenue Form 62A360, "Order Correcting Erroneous Assessment", shall be issued to the collection agency (county sheriff or clerk) and taxpayer correcting an erroneous mineral property tax assessment.

~~(114)~~~~(112)~~ Revenue Form 62A362, "Sheriff's Report of Delinquent Personal Property Tax Bills Transferred to the County Clerk", shall be used by the sheriff to report delinquent personal property tax bills transferred from the sheriff to the county clerk's office.

~~(115)~~~~(113)~~ Revenue Form 62A363, "County Clerk's Claim for Preparing Tax Bills", shall be submitted by the county clerk in order to receive payment for each property tax bill prepared, with one-half (1/2) paid out of the county treasury and one-half (1/2) paid out of the State Treasury.

~~(116)~~~~(114)~~ Revenue Form 62A363-B, "County Clerk's Claim for Preparing Omitted Tax Bills", shall be submitted by the county clerk in order to receive payment of one (1) dollar for each omitted

property tax bill prepared, with one-half (1/2) paid out of the county treasury and one-half (1/2) paid out of the State Treasury.

~~(117)~~~~(115)~~ Revenue Form 62A364, "County Clerk's Monthly Report of Omitted Assessments", shall be used by the county clerk to report omitted assessments made by the property valuation administrator.

~~(118)~~~~(116)~~ Revenue Form 62A365, "Nonresidency Affidavit", shall be filed as proof of nonresidency in Kentucky as of January 1, for ad valorem tax purposes.

~~(119)~~~~(117)~~ Revenue Form 62A366, "Order Correcting Erroneous Assessment", shall be filed by the property valuation administrator with the sheriff, to correct an error made in an assessment of property.

~~(120)~~~~(118)~~ Revenue Form 62A366-D, "Order Correcting Erroneous Delinquent Assessment", shall be filed by the property valuation administrator with the sheriff, to correct an error made in a delinquent assessment of property.

~~(121)~~~~(119)~~ Revenue Form 62A366R, "Exoneration Form for Property Tax Refund", shall be filed by a taxpayer for refunds of property tax.

~~(122)~~~~(120)~~ Revenue Form 62A367, "Authorization for Preparing Additional/Supplemental Property Tax Bills", shall be used by a property valuation administrator to prepare additional or supplemental tax bills.

~~(123)~~~~(121)~~ Revenue Form 62A367-A, "Instructions for Preparation of Additional/Supplemental Tax Bills and Official Receipt", shall be provided to assist the PVA with the preparation of additional or supplemental tax bills.

~~(124)~~~~(122)~~ Revenue Form 62A368-A, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue delinquent property tax collections for the 1997 tax year only.

~~(125)~~~~(123)~~ Revenue Form 62A368-B, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue delinquent property tax collections for tax years after 1997.

~~(126)~~~~(124)~~ Revenue Form 62A369, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue delinquent property tax collections for 1996 and earlier tax years.

~~(127)~~~~(125)~~ Revenue Form 62A369-A, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue state commission from delinquent property tax collections.

~~(128)~~~~(126)~~ Revenue Form 62A370, "Kentucky Department of Revenue Certificate of Registration", shall be issued by the Department of Revenue to individuals, corporations or partnerships proving eligibility to purchase certificates of delinquency. This certificate shall be presented to the county clerk at the time certificates of delinquency are offered for sale.

~~(129)~~~~(127)~~ Revenue Form 62A370A, "Kentucky Department of Revenue Application for Certificate of Registration to Purchase Certificates of Delinquency", shall be submitted to the Department of Revenue by individuals, corporations or partnerships seeking to purchase certificates of delinquency offered for sale by the county clerk.

~~(130)~~~~(128)~~ Revenue Form 62A371, "Attestation Form For Use When Taxpayer Cannot Make Contact With A Third Party Purchaser", shall be used by the taxpayer to attest to the county clerk that the taxpayer attempted to contact the third party purchaser in the manner specified by KRS 134.127(3)(e) and was ~~unsuccessful~~~~successful~~.

~~(131)~~~~(129)~~ Revenue Form 62A372, "Sheriff's List of Orders Correcting Erroneous Assessments", shall be used by the sheriff to report all exoneration made to the tax bills by the property valuation administrator.

~~(132)~~~~(130)~~ Revenue Form 62A372-A, "Certification", shall be used by the sheriff to affirm that the list of exoneration is accurate.

~~(133)~~~~(131)~~ Revenue Form 62A373, "Certificate of Transfer for Property Tax Payment", shall be issued by the sheriff to a person who has paid property taxes on behalf of another and wishes to be treated as a transferee under KRS 134.121.

~~(134)~~~~(132)~~ Revenue Form 62A374, "County Clerk Certificate

of Delinquency Sale Registration", shall be used by the county clerk to register third parties interested in purchasing certificates of delinquency offered for sale by the county clerk.

~~(135)~~~~(133)~~ Revenue Form 62A375, "Release of Certificate of Delinquency Assigned to a Third Party", shall be used by the county clerk to release the lien of a certificate of delinquency that has been refunded to a third party purchaser.

~~(136)~~~~(134)~~ Revenue Form 62A377, "In House Release of Third Party Purchaser Lien When Lien is Paid to Clerk", shall be used by the county clerk to release a certificate of delinquency when the certificate of delinquency has been paid by the taxpayer and the third party purchaser cannot be located.

~~(137)~~~~(135)~~ Revenue Form 62A378, "Report of Mobile Homes and Recreational Vehicles Not Registered in this State", shall be filed by every person providing rental space for mobile homes and recreational vehicles not registered in Kentucky. This form shall be filed with the property valuation administrator of the county in which the park is located.

~~(138)~~~~(136)~~ Revenue Form 62A379, "Listing of Omitted Real Property", shall be used by a taxpayer to voluntarily list any property previously omitted from the tax roll or shall be used by a property valuation administrator to list any involuntarily omitted property.

~~(139)~~~~(137)~~ Revenue Form 62A380, "Notification of Updated Mailing Address from Sheriff to Property Valuation Administrator", shall be used by the sheriff to provide an updated address to the property valuation administrator in accordance with KRS 134.119(8).

~~(140)~~~~(138)~~ Revenue Form 62A384C, "Clay Property Tax Return", shall be filed with the Department of Revenue by persons owning or leasing clay property, reporting the owner's name and address, percent ownership, product tons, and royalty rate.

~~(141)~~~~(139)~~ Revenue Form 62A384C(I) "Instructions to Complete Clay Property Tax Return[for 2013 Tax Year]", shall be used by owners and lessees of land containing mineable clay minerals to file Revenue Form 62A384C.

~~(142)~~~~(140)~~ Revenue Form 62A384-G, "Natural Gas Property Tax Return", shall be filed with the Department of Revenue by persons owning or leasing developed natural gas properties, reporting the location of the property, total yearly gas production, number of producing wells, and the total dollar value of production.

~~(143)~~~~(141)~~ Revenue Form 62A384-G/O(I) "Gas/Oil," shall be used as a letter informing owners of natural gas and oil property of the responsibility to file, the filing deadline, and where to locate the forms.

~~(144)~~~~(142)~~ Revenue Form 62A384L, "Limestone, Sand and Gravel Property Tax Return", shall be filed with the Department of Revenue by persons owning or leasing limestone, sand or gravel properties reporting mineral location, type of mining and production in the last three (3) years.

~~(145)~~~~(143)~~ Revenue Form 62A384-O, "Oil Property Tax Return Lease Report", shall be filed with the Department of Revenue by all persons, corporations, businesses and partnerships owning, leasing or having knowledge of developed oil properties to report developed oil property in Kentucky.

~~(146)~~~~(144)~~ Revenue Form 62A385, "Sheriff's Official Receipt for Property Tax Bills", shall be used by sheriffs to acknowledge receipt of the county's property tax bills and to document the total tax amount to be collected for each taxing district.

~~(147)~~~~(145)~~ Revenue Form 62A385-A, "Sheriff's Receipt For Unpaid and Partially Paid Tax Bills", shall be used by incoming sheriffs to give receipt to the outgoing sheriff for the unpaid and partially paid tax bills outstanding when he or she assumes office.

~~(148)~~~~(146)~~ Revenue Form 62A393, "Sheriff's Property Tax Account Statement", shall be used by the Department of Revenue to conduct the annual property tax settlement with the sheriff.

~~(149)~~~~(147)~~ Revenue Form 62A393-A, "Incoming Sheriff's Property Tax Account Statement", shall be used by the Department of Revenue to conduct the property tax settlement with the incoming sheriff.

~~(150)~~~~(148)~~ Revenue Form 62A393-B, "Outgoing Sheriff's Property Tax Account Statement", shall be used by the Department of Revenue to conduct the property tax settlement with the

outgoing sheriff.

(151)[(149)] Revenue Form 62A394, "Sheriff's Monthly Report of Property Tax Collections", shall be used by sheriffs to report to the Department of Revenue property tax collections for the month.

(152)[(150)] Revenue Form 62A394-MV, "County Clerk's Monthly Report of Motor Vehicle Property Tax Collections", shall be submitted by the county clerk to the Department of Revenue and local taxing jurisdictions to report ad valorem property tax collections for the month.

(153)[(151)] Revenue Form 62A398, "Property Valuation Administrator's Bond", shall be completed by property valuation administrators evidencing surety with the Commonwealth and a local school board and affirming a commitment to fulfill the duties of the office.

(154)[(152)] Revenue Form 62A500(P), "2014[2013] Personal Property Tax Forms and Instructions", shall be the packet of files and instructions relating to Revenue Form 62A500 for use by owners or lessees of tangible personal property reporting taxpayer information, original cost of tangible property and reported value of tangible property with either the property valuation administrator of the county of taxable situs or with the Department of Revenue.

(155)[(153)] Revenue Form 62A500, "2014[2013] Tangible Personal Property Tax Return", shall be filed by owners or lessees of tangible personal property reporting taxpayer information, original cost of tangible property and reported value of tangible property with either the property valuation administrator of the county of taxable situs or with the Department of Revenue.

(156)[(154)] Revenue Form 62A500-A, "2014[2013] Tangible Personal Property Tax Return (Aircraft Assessments Only)", shall be filed by owners or lessees of aircraft not used for commercial purposes, with either the property valuation administrator of the county of taxable situs or with the Department of Revenue, reporting the federal registration number, make and model, and taxpayer's value for each aircraft.

(157)[(155)] Revenue Form 62A500-C, "Consignee Tangible Personal Property Tax Return", shall be filed by persons in possession of consigned inventory, that has not been reported on Revenue Form 62A500, with either the property valuation administrator of the county of taxable situs or the Department of Revenue, reporting consignor information and consigned inventory information.

(158)[(156)] Revenue Form 62A500-L, "Lessee Tangible Personal Property Tax Return", shall be filed by lessees of tangible personal property who did not list the property on Revenue Form 62A500, with either the property valuation administrator of the county of taxable situs or with the Department of Revenue, reporting lessor information and equipment information.

(159)[(157)] Revenue Form 62A500-M1, "Boat Dealer's Used Inventory Listing for Line 31 Tangible Personal Property Tax Return", shall be filed by boat dealers with the property valuation administrator of each county of taxable situs or with the Department of Revenue, containing a detailed listing of used boats held for sale by a licensed boat dealer.

(160)[(158)] Revenue Form 62A500-S1, "Automobile Dealer's Inventory Listing for Line 34 Tangible Personal Property Tax Return", shall be filed by automobile dealers, dealers with new boat and marine equipment held under a floor plan or dealers with new farm machinery held under a floor plan with the property valuation administrator of each county of taxable situs or with the Department of Revenue, containing a detailed listing of property reported on line 34 of the Tangible Personal Property Tax Return.

(161)[(159)] Revenue Form 62A500-W, "2014[2013] Tangible Personal Property Tax Return (Documented Watercraft)", shall be filed by owners or lessees of documented vessels not used for commercial purposes, with either the property valuation administrator of the county of taxable situs or with the Department of Revenue, reporting the coast guard number, make and model and taxpayer's value for each watercraft.

(162)[(160)] Revenue Form 62A600, "Domestic Savings and Loan Tax Return", shall be filed with the Department of Revenue by savings and loans operating solely in Kentucky, reporting the balances in their capital accounts.

(163)[(161)] Revenue Form 62A601, "Foreign Savings and

Loan Tax Return", shall be filed with the Department of Revenue by foreign savings and loans authorized to do business in this state, reporting the balances in their capital accounts.

(164)[(162)] Revenue Form 62A601-S2, "Schedule B, Computation of Exempt Securities", shall be filed with the Department of Revenue, by taxpayers filing Revenue Form 62A600 or 62A601, reporting the market value of U. S. government securities.

(165)[(163)] Revenue Form 62A850, "Bank Deposits Tax Return", shall be filed with the Department of Revenue by financial institutions, reporting the amount of its deposits as of the preceding January 1.

(166)[(164)] Revenue Form 62A862, "Certification of Tax Rate for Bank Deposits Franchise Tax", shall be filed by the local taxing district with the Department of Revenue to notify the Department of Revenue of the rate set on bank deposits.

(167)[(165)] Revenue Form 62A863, "Financial Institutions Local Deposits Summary Report", shall be filed with the Department of Revenue, by financial institutions, reporting all deposits located within the state as of the preceding June 30, along with a copy of the most recent summary of deposits filed with the Federal Deposit Insurance Corporation.

(168)[(166)] Revenue Form 62A863-A, "Schedule A, Summary of Net Deposits", shall be filed with the Department of Revenue, by financial institutions filing Revenue Form 62A863, to summarize deposits.

(169)[(167)] Revenue Form 62A880, "Personal Property Assessment", shall be sent by the Department of Revenue to the owner of omitted personal property notifying him or her of the value assessed by the department as well as all applicable penalties and interest.

(170)[(168)] Revenue Form 62B003, "Unmined Coal Notice of Tax Assessment", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in unmixed coal property.

(171)[(169)] Revenue Form 62B011, "Limestone, Sand, or Gravel Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in limestone, sand or gravel property.

(172)[(170)] Revenue Form 62B012, "Oil Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in oil property.

(173)[(171)] Revenue Form 62B013, "Clay Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in clay property.

(174)[(172)] Revenue Form 62B015, "Gas Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in gas property.

(175)[(173)] Revenue Form 62F003, "Appeals Process for Real Property Assessments", shall be an informational brochure on the procedure to follow to appeal an assessment on real property.

(176)[(174)] Revenue Form 62F015, "PVA Open Records Commercial Fee Guidelines", shall be used by the PVA to establish fees to be charged for the cost of reproduction, creation, or other acquisition of records.

(177)[(175)] Revenue Form 62F031, "Appeal to Local Board of Assessment Appeals", shall be filed with the county clerk by any taxpayer who wishes to appeal his or her assessment on real property.

(178)[(176)] Revenue Form 62F200, "Important Reminder" shall be a postcard mailed to previous filers of the Unmined Coal Property Tax Information Return as a reminder of the responsibility to file, the filing deadline, and where to locate the forms.

(179)[(177)] Revenue Form 62F384-G, "Important Reminder" shall be a postcard mailed to previous filers of the Natural Gas Property Tax Return as a reminder of the responsibility to file, the filing deadline, and where to locate the forms.

(180)[(178)] Revenue Form 62F500, "Important Reminder" shall be a postcard mailed to previous filers of the Tangible Personal Property Tax Return as a reminder of the responsibility to file, the filing deadline and where to locate the forms.

~~(181)~~~~(179)~~ Revenue Form 62F1341, "Exemptions Allowed for Savings and Loans, Savings Banks and Similar Institutions for Intangible Property Tax Purposes", shall inform taxpayers, subject to intangible property tax on the value of their capital stock, of those institutions which issue obligations that are exempt from state ad valorem taxation.

Section 2. Severance Taxes - Required Forms. (1) Revenue Form 10A100, "Kentucky Tax Registration Application", shall be filed by taxpayers with a coal severance and processing tax account listing taxpayer information including mine name and mining permit number.

(2) Revenue Form 10A104, "Update Or Cancellation Of Kentucky Tax Account(s)", shall be used by taxpayers with a coal severance and processing tax account to update business information or to cancel the account.

(3) Revenue Form 55A004, "Coal Severance Tax Seller/Purchaser Certificate", shall be filed by the taxpayer to verify purchase coal deductions.

(4) Revenue Form 55A100, "Coal Severance Tax Return", shall be filed monthly by the taxpayer to report production and tax due.

(5) Revenue Form 55A100, "Part IV - Schedule of Purchased Coal", shall be used by the taxpayer to report coal purchased for processing and resale. "Part V - Schedule for Thin Seam Coal Tax Credit", shall be used by the taxpayer to apply for tax credit for underground mining of thin coal seams.

(6) Revenue Form 55A101, "Coal Severance Tax Return Instructions", shall be included with the coal tax return mailed to the taxpayer to assist in the completion of his or her return.

(7) Revenue Form 55A131, "Credit Memorandum", shall be used by the department to issue a credit to the taxpayer for an overpayment rather than a refund.

(8) Revenue Form 55A209, "Severance Tax Refund Application", shall be used by the taxpayer for the purpose of requesting a refund of tax overpaid.

(9) Revenue Form 56A001, "Application for Certificate of Registration Minerals and Natural Gas Tax", shall be used by persons dealing in minerals, natural gas or natural gas liquids who wish to register with the Department of Revenue to acquire an account number.

(10) Revenue Form 56A100, "Natural Gas and Natural Gas Liquids Tax Return", shall be used by registered natural gas and natural gas liquids taxpayers monthly to report production and tax due.

(11) Revenue Form 56A101, "Minerals Tax Return", shall be used by registered mineral taxpayers monthly to report production and tax due.

(12) Revenue Form 56A106, "Minerals Tax Certificate of Exemption", shall be used by mineral taxpayers to claim exemptions from minerals tax for minerals purchased for the maintenance of a privately maintained but publicly dedicated road.

(13) Revenue Form 56A107, "Schedule A, Allocation of Gross Value of Minerals Severed in Kentucky and Schedule B, Minerals Purchased from Others for Processing by Taxpayer", shall be used by mineral taxpayers to compute gross value of minerals to be allocated and to show the allocation by county of the gross value of minerals severed in Kentucky and also shall be used by a taxpayer for showing minerals that are purchased from others for processing by the taxpayer.

(14) Revenue Form 56A108, "Schedule A, Gross Value of Natural Gas Sold to Nonconsumers and Schedule B, Taxable Gross Value of Natural Gas and Natural Gas Liquids Extracted in Kentucky by Taxpayer - Allocation", shall be used by natural gas taxpayers to show details of all natural gas extracted in Kentucky and sold to nonconsumers and also shall be used by natural gas taxpayers to allocate the natural gas to the county or counties where the natural gas or natural gas liquids were located prior to extraction.

(15) Revenue Form 56A109, "Schedule C, Natural Gas First Purchased by Taxpayer From Kentucky Producers", shall be used by natural gas taxpayers who are first purchasers of natural gas to show gross value by county or counties from which the natural gas

was extracted.

(16) Revenue Form 56A110, "Minerals Tax Return Attachment, Schedule C, Computation of Clay Severed and Processed in Kentucky and Allocation of Tax Attributable to Clay", shall be used by mineral taxpayers that sever clay to compute tax due.

(17) Revenue Form 56A112, "Crude Petroleum Transporter's Monthly Report, Kentucky Oil Production Tax", shall be used by registered crude petroleum transporter's for reporting gross value and tax due.

(18) Revenue Form 56A113, "Minerals Tax Credit for Limestone Sold in Interstate Commerce", shall be used by mineral taxpayers for the purpose of determining the eligibility for the minerals tax credit.

(19) Revenue Form 56A114, "Crude Petroleum Transporter's Application for Registration", shall be used by crude petroleum transporters who wish to acquire an account number with the Kentucky Department of Revenue.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Property tax - referenced material:

1. Revenue Form 61A200(P), "Property Tax Forms and Instructions for Public Service Companies 2014~~[2013]~~", October 2013~~[2012]~~;

2. Revenue Form 61A200, "Public Service Company Property Tax Return for Year Ending December 31, 2013~~[2012]~~", October 2013~~[2012]~~;

3. Revenue Form 61A200(A), "Report of Total Unit System and Kentucky Operations", October 2013~~[2012]~~;

4. Revenue Form 61A200(B), "Report of Kentucky Vehicles, Car Lines and Watercraft", October 2013~~[2012]~~;

5. Revenue Form 61A200(C), "Report of Total Unit Operations Balance Sheet", October 2013~~[2012]~~;

6. Revenue Form 61A200(D), "Report of Total Unit Operations Income Statement", October 2013~~[2012]~~;

7. Revenue Form 61A200(E), "Filing Extension Application", October 2013~~[2012]~~;

8. Revenue Form 61A200(G), "Report of Capital Stocks", October 2013~~[2012]~~;

9. Revenue Form 61A200(H), "Report of Funded Debt", October 2013~~[2012]~~;

10. Revenue Form 61A200(I), "Business Summary by Taxing Jurisdiction", October 2013~~[2012]~~;

11. Revenue Form 61A200(J), "Property Summary by Taxing Jurisdiction, Operating and Nonoperating Property", August 2013~~[2012]~~;

12. Revenue Form 61A200(K), "Operating Property Listing by Taxing Jurisdiction", October 2013~~[2012]~~;

13. Revenue Form 61A200(K2), "Nonoperating/Nonutility Property Listing by Taxing Jurisdiction", October 2013~~[2012]~~;

14. Revenue Form 61A200(L), "Report of Allocation Factors, Operating and Noncarrier Property for All Interstate Companies", October 2013~~[2012]~~;

15. Revenue Form 61A200(M), "Report of Property and Business Factors for Interstate Railroad and Sleeping Car Companies", October 2013~~[2012]~~;

16. Revenue Form 61A200(N1), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", October 2013~~[2012]~~;

17. Revenue Form 61A200(N2), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", October 2013~~[2012]~~;

18. Revenue Form 61A200(N3), "Summary Report of System and Kentucky Operating Lease Payments", October 2013~~[2012]~~;

19. Revenue Form 61A200(O), "Railroad Private Car Mileage Report", October 2013~~[2012]~~;

20. Revenue Form 61A200(Q), "Supplemental Report of Operations for Contained and Residential Landfills", October 2013~~[2012]~~;

21. Revenue Form 61A200(R), "Report of Property Subject to the Pollution Control Tax Exemption", October 2013~~[2012]~~;

22. Revenue Form 61A200(U), "Industrial Revenue Bond Property", October 2013~~[2012]~~;

23. Revenue Form 61A202, "2014[2013] Public Service Company Property Tax Return for Railroad Car Line", October 2013[2012];

24. Revenue Form 61A206(P), "Public Service Company Property Tax Forms and Instructions for Commercial Air Passenger and Air Freight Carriers 2014[2013]", October 2013[2012];

25. Revenue Form 61A206, "Public Service Company Property Tax Return For Commercial Air Passenger and Air Freight Carriers", October 2013[2012];

26. Revenue Form 61A206(A), "Filing Extension Application for Public Service Company Property Tax Return", October 2013[2012];

27. Revenue Form 61A206(B), "Report of Kentucky Registered and Licensed Motor Vehicles", October 2013[2012];

28. Revenue Form 61A206(C), "Report of Financial Operations for Commercial Air Passenger and Air Freight Carriers", October 2013[2012];

29. Revenue Form 61A206(D-1), "Report of System Aircraft Fleet", October 2013[2012];

30. Revenue Form 61A206(D-2), "Report of System Aircraft Fleet", October 2013[2012];

31. Revenue Form 61A206(D-3), "Report of System Aircraft Fleet", October 2013[2012];

32. Revenue Form 61A206(E), "Report of Kentucky Flight Statistics By Airport", October 2013[2012];

33. Revenue Form 61A206(F), "Report of System and Kentucky Allocation Factors", October 2013[2012];

34. Revenue Form 61A206(G), "Report of Funded Debt", October 2013[2012];

35. Revenue Form 61A206(H), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", October 2013[2012];

36. Revenue Form 61A206(I), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", October 2013[2012];

37. Revenue Form 61A206(J), "Summary Report of System and Kentucky Operating Lease Payments", October 2013[2012];

38. Revenue Form 61A206(K), "Report of Owned Real Property Located in Kentucky By Taxing District", October 2013[2012];

39. Revenue Form 61A206(L), "Report of Owned Personal Property Located In Kentucky By Taxing District", October 2013[2012];

40. Revenue Form 61A206(M), "Summary Report of Total System and Kentucky Operations", October 2013[2012];

41. Revenue Form 61A206(N), "Industrial Revenue Bond Property", October 2013[2012];

42. Revenue Form 61A206(O), "Public Service Company Sales", October 2013[2012];

43. Revenue Form 61A207(P), "Commercial Watercraft Personal Property Tax Return 2014[2013]", October 2013[2012];

44. Revenue Form 61A207, "2014[2013] Commercial Watercraft Personal Property Tax Return", October 2013[2012];

45. Revenue Form 61A207(A), "Report of Owned Vessels in Your Possession", October 2013[2012];

46. Revenue Form 61A207(B), "Report of Owned Vessels - in Possession of Others", October 2013[2012];

47. Revenue Form 61A207(C), "Report of Nonowned Vessels in Your Possession", October 2013[2012];

48. Revenue Form 61A207(D), "Commercial Watercraft Valuation Worksheet", October 2013[2012];

49. Revenue Form 61A207(E), "Report of Kentucky Route Miles", October 2013[2012];

50. Revenue Form 61A207(F), "Report of System Route Miles", October 2013[2012];

51. Revenue Form 61A209, "Public Service Company Sales", October 2013[2012];

52. Revenue Form 61A211, "Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs", October 2013[2012];

53. Revenue Form 61A211(I), "Instructions Public Service Company Schedule of Owned and/or Leased Motor Vehicles with

Kentucky Situs", October 2013[2012];

54. Revenue Form 61A211(IP), "Instructions For Editing the Public Service Company Motor Vehicle Printout", March 2013;

55. Revenue Form 61A230, "Notice of Assessment", February 2010;

56.[55.] Revenue Form 61A240, "Notice of Assessment", July 2011;

57.[56.] Revenue Form 61A250, "Notice of Assessment", August 2008;

58.[57.] Revenue Form 61A255, "Public Service Company Property Tax Statement", January 2012;

59.[58.] Revenue Form 61A255(I), "Instructions for 61A255, Public Service Company Property Tax Statement", July 2008;

60.[59.] Revenue Form 61A500(P), "2014[2013] Personal Property Tax Forms and Instructions for Communications Service Providers and Multichannel Video Programming Service Providers", October 2013[2012];

61.[60.] Revenue Form 61A500, "2014[2013] Tangible Personal Property Tax Return for Communications Service Providers and Multichannel Video Programming Service Providers", October 2013[2012];

62.[61.] Revenue Form 61A500(H), "Report of Total Personal Tangible Property in Kentucky", October 2013[2012];

63.[62.] Revenue Form 61A500(I), "Summary of Gross Personal Tangible Property Listing by Taxing District", October 2013[2012];

64.[63.] Revenue Form 61A500(J), "Summary of Reported Personal Tangible Property Listing by Taxing District", October 2013[2012];

65.[64.] Revenue Form 61A500(K), "Personal Tangible Property Listing by Taxing District", October 2013[2012];

66.[65.] Revenue Form 61A508, "Annual Report of Distilled Spirits in Bonded Warehouse", October 2013[2012];

67.[66.] Revenue Form 61A508-S1, "Schedule 1 Department of Property Valuation Cost of Production Schedule", October 2013[2012];

68.[67.] Revenue Form 61A508-S2, "Schedule 2 Department of Property Valuation Storage Cost Schedule", October 2013[2012];

69.[68.] Revenue Form 61A508-S3, "Schedule 3 Schedule of Bulk Sales", October 2013[2012];

70.[69.] Revenue Form 61A508-S4, "Schedule 4", October 2013[2012];

71.[70.] Revenue Form 61A508-S5, "Schedule 5", October 2013[2012];

72. Revenue Form 61A508-S6, "Schedule 6 Industrial Revenue Bond Property", October 2013;

73.[71.] Revenue Form 61A509, "Distilled Spirits or Telecoms Property Tax Statement", January 2012;

74.[72.] Revenue Form 61F007, "Notification Protesting Your Commercial Watercraft Assessment", July 2011;

75.[73.] Revenue Form 61F008, "Notification Protesting Your Assessment", July 2011;

76.[74.] Revenue Form 61F009, "Notification Protesting Your Assessment", July 2011;

77.[75.] Revenue Form 61F010, "Property Value Assessments for Public Service and Centrally Assessed Companies - Assessment of Distilled Spirits in Bonded Warehouses", March 2010;

78.[76.] Revenue Form 62A007, "Motor Vehicle Tax and/or Registration Renewal Notice", 2006;

79.[77.] Revenue Form 62A007S, "Motor Vehicle/Boat Property Tax Notice - Second Notice", 2006;

80.[78.] Revenue Form 62A008, "Motor Vehicle Tax Notice", 2006;

81.[79.] Revenue Form 62A009, "Map Sales Invoice", July, 2006;

82.[80.] Revenue Form 62A010, "Notice for Boat Transfer", 2009;

83.[81.] Revenue Form 62A013, "Application for Assessment Moratorium Certificate", December 2009;

84.[82.] Revenue Form 62A015, "2014[2013] Motor Vehicle and Watercraft Property Tax Rate Certification", 2013[2012];

85.[83.] Revenue Form 62A016, "Quietus", 2012;
 86.[84.] Revenue Form 62A017, "County Clerk's Claim for Calculation of Motor Vehicle and Boat Bills", 2009;
 87.[85.] Revenue Form 62A020, "Intercounty Property Tax Collections", 2009;
 88.[86.] Revenue Form 62A023, "Application for Exemption from Property Taxation", July 2013[December 2011];
 89.[87.] Revenue Form 62A030, "Request for Reproduction of PVA Public Records and Contract for Commercial Users", February 2008;
 90.[88.] Revenue Form 62A044, "Affidavit for Correction/Exoneration of Motor Vehicle/Boat/Trailer Property Tax", February 2009;
 91.[89.] Revenue Form 62A200(P), "2014[2013] Unmined Coal Property Tax Information Return", December 2013[2012];
 92.[90.] Revenue Form 62A200, "2014[2013] Unmined Coal Property Tax Information Return", December 2013[2012];
 93.[91.] Revenue Form 62A200, "Schedule A Fee Property Ownership", December 2013[2012];
 94.[92.] Revenue Form 62A200, "Schedule B Leased Property", December 2013[2012];
 95.[93.] Revenue Form 62A200, "Schedule C Property or Stock Transfers", December 2013[2012];
 96.[94.] Revenue Form 62A200, "Schedule D Lease Terminations, Transfers or Assignments", December 2013[2012];
 97.[95.] Revenue Form 62A200, "Schedule E Farm Exception to Unmined Minerals Tax", December 2013[2012];
 98.[96.] Revenue Form 62A200, "Schedule F Geological Information by County", December 2013[2012];
 99.[97.] Revenue Form 62A301-S, "Omitted Real Estate Property Tax Bill", January 2013;
 100.[98.] Revenue Form 62A302, "Request for Information for Local Board of Tax Appeals", September 2005;
 101.[99.] Revenue Form 62A304, "Property Valuation Administrator's Recapitulation of Real Property Tax Roll", December 2008;
 102.[100.] Revenue Form 62A305, "Property Valuation Administrator's Summary of Real Property Tax Roll Changes (Since Recapitulation)", December 2008;
 103.[101.] Revenue Form 62A307, "Property Owner Conference Record", September 2005;
 104.[102.] Revenue Form 62A323, "Record of Additions and Deletions", December 2008;
 105.[103.] Revenue Form 62A329, "Annual Report of Domestic Life Insurance Companies", August 2010;
 106.[104.] Revenue Form 62A350, "Application for Exemption Under the Homestead/Disability Amendment", December 2011;
 107.[105.] Revenue Form 62A352, "Notice to Real Property Owner of Assessment by Property Valuation Administrator", April 2005;
 108.[106.] Revenue Form 62A353, "Notice of Listing of Omitted Real Property", September 2005;
 109.[107.] Revenue Form 62A354, "Notice to Property Owner of Final Decision of Board of Assessment Appeals", August 2006;
 110.[108.] Revenue Form 62A358, "Receipt for Transferring Delinquent Property Tax Bills From the Sheriff to the County Clerk", December 2009;
 111.[109.] Revenue Form 62A358-S, "Supplemental Receipt to Document Timely Postmarked Payments Received After the Delinquent Tax Bill Transfer Date", March 2010;
 112.[110.] Revenue Form 62A359, "Sheriff's Report of Real Property Tax Bills Transferred to the County Clerk," December 2009;
 113.[111.] Revenue Form 62A360, "Order Correcting Erroneous Assessment", 2011;
 114.[112.] Revenue Form 62A362, "Sheriff's Report of Delinquent Personal Property Tax Bills Transferred to the County Clerk", December 2012;
 115.[113.] Revenue Form 62A363, "County Clerk's Claim for Preparing Tax Bills", December 2007;
 116.[114.] Revenue Form 62A363-B, "County Clerk's Claim for Preparing Omitted Tax Bills", December 2007;
 117.[115.] Revenue Form 62A364, "County Clerk's Monthly

Report of Omitted Assessments", February 2006;
 118.[116.] Revenue Form 62A365, "Nonresidency Affidavit", January 2012;
 119.[117.] Revenue Form 62A366, "Order Correcting Erroneous Assessment", December 2013[2012];
 120.[118.] Revenue Form 62A366-D, "Order Correcting Erroneous Delinquent Assessment", December 2013[2012];
 121.[119.] Revenue Form 62A366R, "Exoneration Form for Property Tax Refund", December 2013[2012];
 122.[120.] Revenue Form 62A367, "Authorization for Preparing Additional/Supplemental Property Tax Bills", December 2008;
 123.[121.] Revenue Form 62A367-A, "Instructions for Preparation of Additional/Supplemental Tax Bills and Official Receipt", November 2011;
 124.[122.] Revenue Form 62A368-A, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
 125.[123.] Revenue Form 62A368-B, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
 126.[124.] Revenue Form 62A369, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
 127.[125.] Revenue Form 62A369-A, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
 128.[126.] Revenue Form 62A370, "Kentucky Department of Revenue Certificate of Registration", November 2009;
 129.[127.] Revenue Form 62A370A, "Kentucky Department of Revenue Application for Certificate of Registration to Purchase Certificates of Delinquency", October 2011;
 130.[128.] Revenue Form 62A371, "Attestation Form For Use When Taxpayer Cannot Make Contact With A Third Party Purchaser", January 2013;
 131.[129.] Revenue Form 62A372, "Sheriff's List of Orders Correcting Erroneous Assessments", February 2006;
 132.[130.] Revenue Form 62A372-A, "Certification", February 2006;
 133.[131.] Revenue Form 62A373, "Certificate of Transfer for Property Tax Payment", January 2010;
 134.[132.] Revenue Form 62A374, "County Clerk Certificate of Delinquency Sale Registration", November 2010;
 135.[133.] Revenue Form 62A375, "Release of Certificate of Delinquency Assigned to a Third Party", February 2011;
 136.[134.] Revenue Form 62A377, "In House Release Of Third Party Purchaser Lien When Lien Is Paid To Clerk", January 2013;
 137.[135.] Revenue Form 62A378, "Report of Mobile Homes and Recreational Vehicles Not Registered in this State", August 2013[2010];
 138.[136.] Revenue Form 62A379, "Listing of Omitted Real Property", December 2013[November 2012];
 139.[137.] Revenue Form 62A380, "Notification of Updated Mailing Address from Sheriff to Property Valuation Administrator", September 2010;
 140.[138.] Revenue Form 62A384C, "Clay Property Tax Return", January 2013;
 141.[139.] Revenue Form 62A384C(I), "Instructions to Complete Clay Property Tax Return[for 2013 Tax Year]", January 2014[2013];
 142.[140.] Revenue Form 62A384-G, "Natural Gas Property Tax Return", January 2013;
 143.[141.] Revenue Form 62A384-G/O(I), "Gas/Oil", January 2014[2013];
 144.[142.] Revenue Form 62A384L, "Limestone, Sand and Gravel Property Tax Return", January 2014[2013];
 145.[143.] Revenue Form 62A384-O, "Oil Property Tax Return Lease Report", January 2013;
 146.[144.] Revenue Form 62A385, "Sheriff's Official Receipt for Property Tax Bills", February 2006;
 147.[145.] Revenue Form 62A385-A, "Sheriff's Receipt for Unpaid and Partially Paid Tax Bills", February 2006;
 148.[146.] Revenue Form 62A393, "Sheriff's Property Tax Account Statement", February 2006;
 149.[147.] Revenue Form 62A393-A, "Incoming Sheriff's Property Tax Account Statement", February 2006;
 150.[148.] Revenue Form 62A393-B, "Outgoing Sheriff's Property Tax Account Statement", February 2006;

151.[149.] Revenue Form 62A394, "Sheriff's Monthly Report of Property Tax Collections", January 2010;

152.[150.] Revenue Form 62A394-MV, "County Clerk's Monthly Report of Motor Vehicle Property Tax Collections", August 2011;

153.[151.] Revenue Form 62A398, "Property Valuation Administrator's Bond", September 2010;

154.[152.] Revenue Form 62A500(P), "2014[2013] Personal Property Tax Forms and Instructions", November 2013[2012];

155.[153.] Revenue Form 62A500, "2014[2013] Tangible Personal Property Tax Return", November 2013[2012];

156.[154.] Revenue Form 62A500-A, "2014[2013] Tangible Personal Property Tax Return (Aircraft Assessments Only)", November 2013[2012];

157.[155.] Revenue Form 62A500-C, "Consignee Tangible Personal Property Tax Return", November 2013[2012];

158.[156.] Revenue Form 62A500-L, "Lessee Tangible Personal Property Tax Return", November 2013[2012];

159.[157.] Revenue Form 62A500-M1, "Boat Dealer's Used Inventory Listing for Line 31 Tangible Personal Property Tax Return", November 2013[2012];

160.[158.] Revenue Form 62A500-S1, "Automobile Dealer's Inventory Listing for Line 34 Tangible Personal Property Tax Return", November 2013[2012];

161.[159.] Revenue Form 62A500-W, "2014[2013] Tangible Personal Property Tax Return (Documented Watercraft)", November 2013[2012];

162.[160.] Revenue Form 62A600, "Domestic Savings and Loan Tax Return", August 2013[2011];

163.[161.] Revenue Form 62A601, "Foreign Savings and Loan Tax Return", August 2013[2011];

164.[162.] Revenue Form 62A601-S2, "Schedule B, Computation of Exempt Securities", August 2013[2011];

165.[163.] Revenue Form 62A850, "Bank Deposits Tax Return", August 2013[2011];

166.[164.] Revenue Form 62A862, "Certification of Tax Rate for Bank Deposits Franchise Tax", August 2011;

167.[165.] Revenue Form 62A863, "Financial Institutions Local Deposits Summary Report", August 2013[2011];

168.[166.] Revenue Form 62A863-A, "Schedule A, Summary of Net Deposits", August 2013[2011];

169.[167.] Revenue Form 62A880, "Personal Property Assessment", October 2004;

170.[168.] Revenue Form 62B003, "Unmined Coal Notice of Tax Assessment", November 2008;

171.[169.] Revenue Form 62B011, "Limestone, Sand, or Gravel Assessment Notice", July 2006;

172.[170.] Revenue Form 62B012, "Oil Assessment Notice", July 2006;

173.[171.] Revenue Form 62B013, "Clay Assessment Notice", July 2006;

174.[172.] Revenue Form 62B015, "Gas Assessment Notice", July 2006;

175.[173.] Revenue Form 62F003, "Appeals Process for Real Property Assessments", May 2009;

176.[174.] Revenue Form 62F015, "PVA Open Records Commercial Fee Guidelines", August 2012;

177.[175.] Revenue Form 62F031, "Appeal to Local Board of Assessment Appeals", January 2010;

178.[176.] Revenue Form 62F200, "Important Reminder", January 2014[2013];

179.[177.] Revenue Form 62F384-G, "Important Reminder", January 2014[2013];

180.[178.] Revenue Form 62F500, "Important Reminder", December 2013[2012]; and

181.[179.] Revenue Form 62F1341, "Exemptions Allowed for Savings and Loans, Savings Banks and Similar Institutions for Intangible Property Tax Purposes", August 2011; and

(b) Severance taxes - referenced material:

1. Revenue Form 10A100, "Kentucky Tax Registration Application", July 2013[August 2012];

2. Revenue Form 10A104, "Update or Cancellation of Kentucky Account(s)", June 2011;

3. Revenue Form 55A004, "Coal Severance Tax Seller/Purchaser Certificate", October 2010;

4. Revenue Form 55A100, "Coal Severance Tax Return", October 2010;

5. Revenue Form 55A100, "Part IV - Schedule of Purchased Coal" and "Part V - Schedule for Thin Seam Coal Tax Credit", October 2010;

6. Revenue Form 55A101, "Coal Severance Tax Return Instructions", October 2010;

7. Revenue Form 55A131, "Credit Memorandum", December 2006;

8. Revenue Form 55A209, "Severance Tax Refund Application", August 2009;

9. Revenue Form 56A001, "Application for Certificate of Registration Minerals and Natural Gas Tax", October 1984;

10. Revenue Form 56A100, "Natural Gas and Natural Gas Liquids Tax Return", July 2004;

11. Revenue Form 56A101, "Minerals Tax Return", July 2004;

12. Revenue Form 56A106, "Minerals Tax Certificate of Exemption", December 2006;

13. Revenue Form 56A107, "Schedule A, Allocation of Gross Value of Minerals Severed in Kentucky and Schedule B, Minerals Purchased from Others for Processing by Taxpayer", January 2005;

14. Revenue Form 56A108, "Schedule A, Gross Value of Natural Gas Sold to Nonconsumers and Schedule B, Taxable Gross Value of Natural Gas and Natural Gas Liquids Extracted in Kentucky by Taxpayer - Allocation", March 2005;

15. Revenue Form 56A109, "Schedule C, Natural Gas First Purchased by Taxpayer from Kentucky Producers", January 2005;

16. Revenue Form 56A110, "Minerals Tax Return Attachment, Schedule C, Computation of Clay Severed and Processed in Kentucky and Allocation of Tax Attributable to Clay", March 2005;

17. Revenue Form 56A112, "Crude Petroleum Transporter's Monthly Report, Kentucky Oil Production Tax", July 2004;

18. Revenue Form 56A113, "Minerals Tax Credit for Limestone Sold in Interstate Commerce", November 1997; and

19. Revenue Form 56A114, "Crude Petroleum Transporter's Application for Registration", December 2006.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40620, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21st, 2014 from 10:00 a.m. till 12:00 p.m. in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend this hearing was 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 February 28th, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Office of General Counsel, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9526, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of Property and Severance Taxes by the Department of Revenue.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order for the Department of Revenue to meet the requirements of KRS Chapter 13A.110 which requires that forms required to be submitted by a regulated entity shall be included in an administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of Property and Severance Taxes by the Department of Revenue.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation incorporates by reference the required forms used in the administration of Property and Severance Taxes by the Department of Revenue.

(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 contains tax forms to be used for tax year 2014.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to update tax forms for the tax year 2014.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of the tax laws.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide taxpayers with the necessary tax forms to file and pay personal tangible and public service property taxes for tax years beginning in 2014.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All Kentucky taxpayers and their representatives will be affected by the listing of forms administered by the Department of Revenue in an administrative regulation. Local government will be affected to the extent they utilize forms administered by the Department of Revenue. The Department of Revenue will be affected to the extent that it administers the referenced forms.

(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: As forms are changed, the manuals and the Department of Revenue Website in which copies of all forms listed in this regulation are maintained will be updated.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): All taxpayers and the administering agencies will benefit by having access to a centralized listing of the most current forms in use.

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

(a) Initially: The Department of Revenue will not incur additional cost as the result of this regulation.

(b) On a continuing basis: The Department of Revenue will not

incur additional costs as the result of this regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Department of Revenue agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: This administrative regulation does not require an increase in fees or funding.

(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 either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied because the requirements of this regulation apply to every taxpayer.

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 Finance and Administration Cabinet, Department of Revenue, Office of Property Valuation, Local Valuation Branch, State Valuation Branch and Mineral/GIS Services Branch.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 131.130(1)

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? The administrative cost will be absorbed in the normal operating cost of the department.

(d) How much will it cost to administer this program for subsequent years? The administrative cost will be absorbed in the normal operating budget of the department.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 103 KAR 3:040E

This emergency administrative regulation is being promulgated in order to provide Kentucky taxpayers the forms and information necessary to comply with Kentucky tax laws. This administrative regulation must be filed as soon as possible in order to incorporate by reference such tax forms and instructions as may be needed by taxpayers and their representative to comply with Kentucky tax laws. An ordinary administrative regulation is not sufficient, because the public relies on these forms and instructions in order to make timely and accurate filing of tax returns and payment of the correct amount of tax due. This emergency administrative regulation shall be replaced by an ordinary administrative regulation which is being filed with the Regulations Compiler along with this emergency administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
THOMAS B. MILLER, Commissioner

FINANCE AND ADMINISTRATION CABINET
Department of Revenue
Office of Income Taxation
(Emergency Amendment)

103 KAR 3:040E. Income Tax Forms Manual.

RELATES TO: KRS 131.041, 131.051, 131.061, 131.071, 131.081, 131.110, 131.130, 131.155, 131.170, 131.180, 131.190, 131.250, 131.340, 131.500, 131.510(1), (2)(a), 131.540, 141.010, 141.0101, 141.011, 141.016, 141.020, 141.0202, 141.030, 141.040, 141.0401, 141.0405, 141.041, 141.042, 141.044, 141.062, 141.065, 141.066, 141.067, 141.068, 141.069, 141.070, 141.071, 141.120, 141.121, 141.160, 141.170, 141.180, 141.200, 141.205, 141.206, 141.207, 141.208, 141.300, 141.310, 141.325, 141.330, 141.335, 141.347, 141.370, 141.381, 141.382, 141.383, 141.384, 141.385, 141.386, 141.390, 141.392, 141.395, 141.400, 141.401, 141.402, 141.403, 141.405, 141.407, 141.412, 141.415, 141.418, 141.420, 141.421, 141.423, 141.424, 141.4242, 141.4244, 141.428, 141.430, 141.434, 141.436, 141.437, 141.438, 141.985, 141.990, 151B.127, 154.12-2086, 154.20-050, 154.22-060, 154.23-035, 154.24-110, 154.25-030, 154.26-090, 154.28-090, 154.32-010, 154.34-080, 154.45-090, 154.48-025, 155.170

STATUTORY AUTHORITY: KRS 131.130(3)

EFFECTIVE: December 27, 2013

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue forms used in the administration of income taxes by the Department of Revenue.

Section 1. Corporation Income Taxes. (1) Revenue Form 41A720, "Form 720, 2013[2012] Kentucky Corporation Income Tax and LLET Return", shall be used by a C corporation to determine its corporation income tax due in accordance with KRS 141.040 and its limited liability entity tax due in accordance with KRS 141.0401 for tax years beginning in 2013[2012].

(2) Revenue Form 41A720A, "Schedule A, Apportionment and Allocation (For corporations and pass-through entities taxable both within and without Kentucky)", shall be used by a corporation or a pass-through entity taxable both within and without Kentucky to apportion and allocate its net income to Kentucky in accordance with KRS 141.120 or 141.206.

(3) Revenue Form 41A720A-C, "Schedule A-C, Apportionment and Allocation - Continuation Sheet (For corporations and pass-through entities taxable both within and without Kentucky)", shall be used by a corporation or a pass-through entity taxable both within and without Kentucky that is also a partner or member of a pass-through entity to determine the sales, property and payroll amounts to be entered on Revenue Form 41A720A.

(4) Revenue Form 41A720A-N, "Schedule A-N, Apportionment Factor Schedule (For a Nexus Consolidated Tax Return)", shall be used by a corporation filing a mandatory nexus consolidated return to show the Kentucky and total sales, property, and payroll of the corporation and each subsidiary included in the apportionment factor.

(5) Revenue Form 41A720BIO, "Schedule BIO, Application and Credit Certificate of Income Tax/LLET Credit Biodiesel", shall be used by a taxpayer who is a biodiesel producer, biodiesel blender, or renewable diesel producer to report the biodiesel gallons produced or used by the blender and request approval from the Kentucky Department of Revenue of the tax credit amount allowed by KRS 141.423.

(6) Revenue Form 41A720CC, "Schedule CC, Coal Conversion Tax Credit", shall be used by a corporation to compute the tax credit allowed by KRS 141.041 for coal used or substituted for other fuels in an eligible heating facility as described by KRS 141.041(1).

(7) Revenue Form 41A720-CCI, "Schedule CCI, Application and Credit Certificate of Clean Coal Incentive Tax Credit", shall be used by a taxpayer to request approval from the Department of Revenue of the tax credit amount allowed by KRS 141.428 for the purchase of Kentucky coal used by the taxpayer to generate electricity.

(8) Revenue Form 41A720CELL, "Schedule CELL, Application and Credit Certificate of Income Tax/LLET Credit Cellulosic Ethanol", shall be used by a taxpayer who is a producer of cellulosic ethanol to report the number of cellulosic ethanol gallons and request approval from the Department of Revenue of the tax credit amount allowed by KRS 141.4244.

(9) Revenue Form 41A720-CI, "Schedule CI, Application for Coal Incentive Tax Credit", shall be used by a taxpayer to request approval for the amount of tax credit allowed by KRS 141.0405 for the purchase of Kentucky coal used by the taxpayer to generate electricity.

(10) Revenue Form 41A720COGS, "Schedule COGS, Limited Liability Entity Tax Cost of Goods Sold", shall be used by a taxpayer to compute its Kentucky cost of goods sold and its total costs of goods sold from all sources for purposes of computing its limited liability entity tax based on gross profits.

(11) Revenue Form 41A720CR, "Schedule CR, Pro Forma Federal Consolidated Return Schedule", shall be used by a C corporation filing a consolidated return to show its federal pro forma consolidated return.

(12)(~~11~~) Revenue Form 41A720CR-C, "Schedule CR-C, Pro Forma Federal Consolidated Return Schedule Continuation Sheet", shall be used by a C corporation filing a consolidated return as a continuation of Revenue Form 41A720CR.

(13)(~~12~~) Revenue Form 41A720ES, "Form 720-ES Kentucky, 2014[2013] Corporation Income/Limited Liability Entity Tax Estimated Tax Voucher", shall be used by a corporation or a limited liability pass-through entity to submit payments of estimated corporation income or limited liability entity tax as required by KRS 141.044.

(14)(~~13~~) Revenue Form 41A720ETH, "Schedule ETH, Application and Credit Certificate of Income Tax/LLET Credit Ethanol", shall be used by a taxpayer who is a producer of ethanol to report ethanol gallons produced and request approval from the Kentucky Department of Revenue of the tax credit amount allowed by KRS 141.4242.(~~14~~) Revenue Form 41A720EZC, "Schedule EZC, Enterprise Zone Tax Credit", shall be used by a qualified taxpayer to determine the tax credit allowed by KRS 154.45-090.]

(15) Revenue Form 41A720FD, "Schedule FD, Food Donation Tax Credit", shall be used by a taxpayer who provides edible agricultural products to a nonprofit food program operating in Kentucky to determine the credit allowed by KRS 141.392.

(16) Revenue Form 41A720HH, "Schedule HH, Kentucky Housing for Homeless Families Deduction", shall be used by an individual, corporation, fiduciary, or pass-through entity to determine the deduction allowed by KRS 141.0202.

(17)(~~16~~) Revenue Form 41A720(I), "Instructions, 2013[2012] Kentucky Corporation Income Tax and LLET Return", shall be used by a corporation to file its 2013[2012] Kentucky Corporation Income Tax and LLET Return and related schedules.

(18)(~~17~~) Revenue Form 41A720KCR, "Schedule KCR, Kentucky Consolidated Return Schedule", shall be used by a C corporation filing a nexus consolidated return showing the income or loss of each entity included in the nexus consolidated tax return.

(19)(~~18~~) Revenue Form 41A720KCR-C, "Schedule KCR-C, Kentucky Consolidated Return Schedule - Continuation Sheet", shall be used by a C corporation filing a nexus consolidated return as a continuation of Revenue Form 41A720KCR.

(20)(~~19~~) Revenue Form 41A720KESA, "Schedule KESA, Tax Credit Computation Schedule (For a KESA Project of a Corporation)", shall be used by a corporation which has entered into an agreement for a Kentucky Environmental Stewardship Act (KESA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.430.

(21)(~~20~~) Revenue Form 41A720KESA-SP, "Schedule KESA-SP, Tax Credit Computation Schedule (For a KESA Project of a

Pass-Through Entity)", shall be used by a pass-through entity which has entered into an agreement for a Kentucky Environmental Stewardship Act (KESA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.430.

(22)[(21)] Revenue Form 41A720KESA-T, "Schedule KESA-T, Tracking Schedule for a KESA Project", shall be used by a company which has entered into an agreement for a Kentucky Environmental Stewardship Act (KESA) project to maintain a record of the approved costs and tax credits for the duration of the agreement.

(23)[(22)] Revenue Form 41A720LLET, "Schedule LLET, Limited Liability Entity Tax", shall be used by a corporation or a limited liability pass-through entity to determine the limited liability entity tax in accordance with KRS 141.0401.

(24)[(23)] Revenue Form 41A720LLET-C, "Schedule LLET-C, Limited Liability Entity Tax - Continuation Sheet", shall be used by a corporation or a limited liability pass-through entity that is a partner in a general partnership organized or formed as a general partnership after January 1, 2006, or a partner or member in a limited liability pass-through entity to determine its Kentucky gross receipts and Kentucky gross profits and its total gross receipts and total gross profits from all sources to be entered on Revenue Form 41A720LLET.

(25)[(24)] Revenue Form 41A720LLET(K), "Schedule LLET(K), Limited Liability Entity Tax (For a Limited Liability Pass-through Entity with Economic Development Project(s))", shall be used by limited liability pass-through entities with economic development projects to determine the limited liability entity tax in accordance with KRS 141.0401.

(26)[(25)] Revenue Form 41A720LLET(K)-C, "Schedule LLET(K)-C, Limited Liability Entity Tax - Continuation Sheet (For a Limited Liability Pass-Through Entity with Economic Development Projects)", shall be used by a limited liability pass-through entity with an economic development project that is a partner or member of a limited liability pass-through entity or a general partnership organized or formed as a general partnership after January 1, 2006, to determine its Kentucky gross receipts and Kentucky gross profits and its total gross receipts and total gross profits from all sources to be entered on Revenue Form 41A720LLET(K).

(27)[(26)] Revenue Form 41A720NOL, "Schedule NOL, Net Operating Loss Schedule", shall be used by a C corporation with a current year net operating loss or net operating loss carry-forward.

(28)[(27)] Revenue Form 41A720NOL-CF, "Schedule NOL-CF, Kentucky NOL Carry forward Schedule", shall be used by a corporation filing a nexus consolidated income tax return as provided by KRS 141.200, in addition to Revenue Form 41A720NOL, to show the Kentucky net operating loss (KNOL) carry forward balance for each new member of the affiliated group.

(29)[(28)] Revenue Form 41A720-O, "Schedule O-720, Other Additions and Subtractions To/From Federal Taxable Income", shall be used by a corporation filing Kentucky Form 720 to show other additions to and subtractions from federal taxable income on Revenue Form 41A720, Part III, Lines 9 and 16, respectively.

(30)[(29)] Revenue Form 41A720QR, "Schedule QR, Qualified Research Facility Tax Credit", shall be used by a corporation, individual, or pass-through entity to determine the credit against the income tax liability or LLET liability allowed by KRS 141.395.

(31)[(30)] Revenue Form 41A720RC, "Schedule RC, Application for Income Tax/LLET Credit for Recycling and/or Composting Equipment or Major Recycling Project", shall be used by a taxpayer to request approval for the amount of credit allowed by KRS 141.390 for the purchase and installation of recycling or composting equipment or a major recycling project. This form shall also be used by an individual, corporation, fiduciary, or pass-through entity to substantiate and keep a record of the amount of approved credit claimed on their tax return.

(32)[(31)] Revenue Form 41A720RC-C, "Schedule RC-C, Schedule RC - Part I Continuation", shall be used by an individual, corporation, fiduciary, or pass-through entity, in addition to Revenue Form 41A720RC, to list additional equipment for which approval of the credit allowed by KRS 141.390 is being requested.

(33)[(32)] Revenue Form 41A720RC(I), "Instructions for

Schedule RC", shall be used by taxpayers filing Revenue Form 41A720RC and Revenue Form 41A720RC-C requesting approval of a tax credit for recycling equipment, composting equipment, or a major recycling project.

(34)[(33)] Revenue Form 41A720RC-R, "Schedule RC-R, Recycling or Composting Equipment Tax Credit Recapture", shall be used by a taxpayer disposing of recycling or composting equipment before the end of the recapture period to compute the tax credit recaptured to be reported on the applicable tax return.

(35)[(34)] Revenue Form 41A720RPC, "Schedule RPC, Related Party Costs Disclosure Statement," shall be used by an entity to report related party expenses and the exceptions to the required disallowance of related party expenses as provided by KRS 141.205.

(36)[(35)] Revenue Form 41A720RR-E, "Schedule RR-E, Application and Credit Certificate of Income Tax/LLET Credit Railroad Expansion", shall be used by a corporation or pass-through entity requesting approval of a railroad expansion tax credit allowed by KRS 141.386.

(37)[(36)] Revenue Form 41A720RR-I, "Schedule RR-I, Railroad Maintenance and Improvement Tax Credit", shall be used by a corporation, individual, or pass-through entity to determine the credit against the income tax liability or LLET liability allowed by KRS 141.385.

(38)[(37)] Revenue Form 41A720S, "Form 720S, 2013[2012] Kentucky S Corporation Income Tax and LLET Return", shall be used by an S corporation to determine the amount of tax due in accordance with KRS 141.040 and 141.0401 and to report the shareholders' share of income, loss, credits, deductions, etc. for tax years beginning in 2013[2012].

(39)[(38)] Revenue Form 41A720S(I), "Instructions, 2013[2012] Kentucky S Corporation Income Tax and LLET Return", shall be used by an S corporation to file its 2013[2012] Kentucky S Corporation Income Tax and LLET Return and related schedules.

(40)[(39)] Revenue Form 41A720S(K), "Form 720S(K), Kentucky Schedule K for S Corporations With Economic Development Project(s)", shall be used for tax years beginning in 2013[2012] by S Corporations with economic development projects to determine the shareholders' shares of income, credit, deductions, etc., excluding the economic development projects.

(41)[(40)] Revenue Form 41A720S(K-1), "Schedule K-1 (Form 720S), 2013[2012] Shareholder's Share of Income, Credits, Deductions, Etc.", shall be used by an S corporation to report to each of its shareholders the amount of income, credit, deduction, etc., that the shareholder shall report for Kentucky income tax purposes.

(42)[(41)] Revenue Form 41A720S-O, "Schedule O-PTE, Other Additions and Subtractions To/From Federal Ordinary Income", shall be used by a pass-through entity filing Revenue Form 41A720S, Form 41A765, or Form 42A765-GP to show other additions to and subtractions from federal ordinary income on Revenue Form 41A720S, 41A765, or 42A765-GP Part I, Lines 5 and 9, respectively.

(43)[(42)] Revenue Form 41A720SL, "Application for Six-Month Extension of Time to File Kentucky Corporation or Limited Liability Pass-Through Entity Return", shall be used by a corporation or a limited liability pass-through entity to request a six (6) month extension of time to file a tax return or an LLET return or to submit payment of unpaid tax.

(44)[(43)] Revenue Form 41A720TCS, "Schedule TCS, Tax Credit Summary Schedule", shall be used by a corporation or a limited liability pass-through entity to summarize tax credits claimed and shall be attached to the tax return.

(45)[(44)] Revenue Form 41A720VERB, "Schedule VERB, Voluntary Environmental Remediation Tax Credit", shall be used by an entity claiming a tax credit provided by KRS 141.418.

(46)[(45)] Revenue Form 41A720-S1, "Form 720X, Amended Kentucky Corporation Income Tax and Corporation License Tax Return", shall be used by a C corporation to amend its Kentucky Corporation Income and License Tax Return for tax periods beginning prior to January 1, 2005, as previously filed.

(47)[(46)] Revenue Form 41A720-S2, "Form 720-AMENDED, Amended Kentucky Corporation Income Tax Return", shall be used

by a C corporation to amend its Kentucky Corporation Income Tax Return for periods beginning on or after January 1, 2005 and before January 1, 2007, as previously filed.

(48) [(47)] Revenue Form 41A720-S3, "Form 720-AMENDED (2007-2008), Amended Kentucky Corporation Income Tax and LLET Return", shall be used by a C corporation to amend its Kentucky Corporation Income Tax and LLET Return for periods beginning on or after January 1, 2007 and before January 1, 2009, as previously filed.

(49) [(48)] Revenue Form 41A720-S4, "Form 851-K, Kentucky Affiliations and Payment Schedule", shall be used by a corporation filing a consolidated Kentucky income tax return on Revenue Form 41A720 to identify the members of the affiliated group which are subject to the Kentucky corporation tax and to list the amount of tax paid.

(50) [(49)] Revenue Form 41A720-S6, "Form 2220-K, Underpayment and Late Payment of Estimated Income Tax and LLET", shall be used by a corporation or limited liability pass-through entity required by KRS 141.042 and 141.044 to file a declaration of estimated tax, to compute the underpayment penalty as provided by KRS 131.180(3) and 141.990, and to compute the interest on any late payment or underpayment of an estimated tax installment as provided by KRS [(131.183(2) and] 141.985.

(51) [(50)] Revenue Form 41A720-S7, "Form 5695-K, Kentucky Energy Efficiency Products Tax Credit", shall be used by a taxpayer to claim a tax credit for installation of energy efficiency products for residential and commercial property as provided by KRS 141.436.

(52) Revenue Form 41A720-S8, "Form 8879(C) – K, Kentucky Corporation or Pass-Through Entity Tax Return Declaration for Electronic Filing", shall be used by a taxpayer as a declaration document and signature authorization for an electronic filing of a Kentucky income or LLET return.

(53) [(51)] Revenue Form 41A720-S9, "Form 8903-K, Kentucky Domestic Production Activities Deduction", shall be used by a corporation to determine the Domestic Production Activities Deduction amount for Kentucky corporation income tax purposes and shall be attached to the corporation income tax return.

(54) [(52)] Revenue Form 41A720-S11, "Form 8908-K, Kentucky ENERGY STAR (Homes and Manufactured Homes) Tax Credit", shall be used by a taxpayer to claim a tax credit for the construction of an ENERGY STAR home or the sale of an ENERGY STAR manufactured home as provided by KRS 141.437.

(55) Revenue Form 41A720-S12, "Form 720-V, Electronic Filing Payment Voucher", shall be used by an entity filing an electronic Kentucky tax return to pay the balance of tax due.

(56) [(53)] Revenue Form 41A720-S16, "Schedule KREDA, Tax Credit Computation Schedule (For a KREDA Project of a Corporation)", shall be used by a corporation which has a Kentucky Rural Economic Development Act (KREDA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.347.

(57) [(54)] Revenue Form 41A720-S17, "Schedule KREDA-T, Tracking Schedule for a KREDA Project", shall be used by a company which has a Kentucky Rural Economic Development Act (KREDA) project to maintain a record of the debt service payments, wage assessment fees and tax credits for the duration of the project.

(58) [(55)] Revenue Form 41A720-S18, "Schedule KREDA-SP, Tax Computation Schedule (For a KREDA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Rural Economic Development Act (KREDA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.347.

(59) [(56)] Revenue Form 41A720-S20, "Schedule KIDA, Tax Credit Computation Schedule (For a KIDA Project of a Corporation)", shall be used by a corporation which has a Kentucky Industrial Development Act (KIDA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.400.

(60) [(57)] Revenue Form 41A720-S21, "Schedule KIDA-T,

Tracking Schedule for a KIDA Project", shall be used by a company which has a Kentucky Industrial Development Act (KIDA) project to maintain a record of the debt service payments and tax credits for the duration of the project.

(61) [(58)] Revenue Form 41A720-S22, "Schedule KIDA-SP, Tax Computation Schedule (For a KIDA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Industrial Development Act (KIDA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.400.

(62) [(59)] Revenue Form 41A720-S24, "Schedule KIRA, Tax Credit Computation Schedule (For a KIRA Project of a Corporation)", shall be used by a corporation which has a Kentucky Industrial Revitalization Act (KIRA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.403.

(63) [(60)] Revenue Form 41A720-S25, "Schedule KIRA-T, Tracking Schedule for a KIRA Project", shall be used by a company which has a Kentucky Industrial Revitalization Act (KIRA) project to maintain a record of the approved costs, wage assessment fees and tax credits for the duration of the project.

(64) [(61)] Revenue Form 41A720-S26, "Schedule KIRA-SP, Tax Computation Schedule (For a KIRA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Industrial Revitalization Act (KIRA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.403.

(65) [(62)] Revenue Form 41A720-S27, "Schedule KJDA, Tax Credit Computation Schedule (For a KJDA Project of a Corporation)", shall be used by a corporation which has a Kentucky Jobs Development Act (KJDA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.407.

(66) [(63)] Revenue Form 41A720-S28, "Schedule KJDA-T, Tracking Schedule for a KJDA Project", shall be used by a company which has a Kentucky Jobs Development Act (KJDA) project to maintain a record of the approved costs, wage assessment fees, in-lieu-of credits and tax credits for the duration of the project.

(67) [(64)] Revenue Form 41A720-S29, "Schedule KJDA-SP, Tax Computation Schedule (For a KJDA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Jobs Development Act (KJDA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.407.

(68) [(65)] Revenue Form 41A720-S35, "Schedule KRA, Tax Credit Computation Schedule (For a KRA Project of a Corporation)", shall be used by a corporation which has entered into a Kentucky Reinvestment Act (KRA) project to compute the allowable KRA credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

(69) [(66)] Revenue Form 41A720-S36, "Schedule KRA-SP, Tax Computation Schedule (For a KRA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Reinvestment Act (KRA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

(70) [(67)] Revenue Form 41A720-S37, "Schedule KRA-T, Tracking Schedule For a KRA Project", shall be used by a company which has entered into a Kentucky Reinvestment Act (KRA) project to maintain a record of the balance of approved costs and tax credits for the duration of the agreement.

(71) [(68)] Revenue Form 41A720-S40, "Schedule KEOZ, Tax Credit Computation Schedule (For a KEOZ Project of a Corporation)", shall be used by a corporation which has entered into a Kentucky Economic Opportunity Zone (KEOZ) Act project to compute the allowable KEOZ credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.401.

(72) [(69)] Revenue Form 41A720-S41, "Schedule KEOZ-SP, Tax Computation Schedule (For a KEOZ Project of a Pass-Through Entity)", shall be used by a pass-through entity which has

entered into a Kentucky Economic Opportunity Zone (KEOZ) Act project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.401.

(73)[(70)] Revenue Form 41A720-S42, "Schedule KEOZ-T, Tracking Schedule for a KEOZ Project", shall be used by a company which has entered into an agreement for a Kentucky Economic Opportunity Zone (KEOZ) Act project to maintain a record of the debt service payments, wage assessment fees, approved costs and tax credits for the duration of the agreement.

(74)[(71)] Revenue Form 41A720-S45, "Schedule KJRA, Tax Credit Computation Schedule (For a KJRA Project of a Corporation)", shall be used by a company which has entered into a Kentucky Jobs Retention Act (KJRA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.402.

(75)[(72)] Revenue Form 41A720-S46, "Schedule KJRA-T, Tracking Schedule For a KJRA Project", shall be used by a company which has entered into an agreement for a Kentucky Jobs Retention Act (KJRA) project to maintain a record of the debt service payments, wage assessment fees, approved costs, and tax credits for the duration of the agreement.

(76)[(73)] Revenue Form 41A720-S47, "Schedule KJRA-SP, Tax Computation Schedule (For a KJRA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into a Kentucky Jobs Retention Act (KJRA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.402.

(77)[(74)] Revenue Form 41A720-S50, "Schedule IEIA, Tax Credit Computation Schedule (For an IEIA Project of a Corporation)", shall be used by a company which has entered into an Incentives for Energy Independence Act (IEIA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.421.

(78)[(75)] Revenue Form 41A720-S51, "Schedule IEIA-T, Tracking Schedule for an IEIA Project", shall be used by a company which has entered into an Incentives for Energy Independence Act (IEIA) project to maintain a record of the balance of approved costs, wage assessments, and tax credits for the duration of the agreement.

(79)[(76)] Revenue Form 41A720-S52, "Schedule IEIA-SP, Tax Computation Schedule (For an IEIA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into an Incentives for Energy Independence Act (IEIA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.421.

(80)[(77)] Revenue Form 41A720-S53, "Schedule KBI, Tax Credit Computation Schedule (For a KBI Project of a Corporation)", shall be used by a corporation which has entered into a Kentucky Business Investment (KBI) project to compute the allowable KBI credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

(81)[(78)] Revenue Form 41A720-S54, "Schedule KBI-SP, Tax Computation Schedule (For a KBI Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into a Kentucky Business Investment (KBI) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

(82)[(79)] Revenue Form 41A720-S55, "Schedule KBI-T, Tracking Schedule for a KBI Project", shall be used by a company which has entered into an agreement for a Kentucky Business Investment (KBI) project to maintain a record of approved costs, wage assessments, and tax credits for the duration of the agreement.

(83) Revenue Form 41A720-S56, "Schedule FON, Tax Credit Computation Schedule (For a FON project of a corporation)", shall be used by a corporation which has a Farm Operation Networking Project (FON) to compute the allowable FON credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.412.

(84) Revenue Form 41A720-S57, "Schedule FON-SP, Tax Computation Schedule (For a FON project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Farm Operation Networking Project (FON) to determine the allowable FON credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.412.

(85) Revenue Form 41A720-S58, "Schedule FON-T, Tracking Schedule for a FON Project", shall be used by a company with a Farm Operation Networking Project (FON) to maintain a record of approved costs and the tax credits taken for the duration of the project.

(86)[(80)] Revenue Form 41A720-S80, "Form 8874(K), Application for Certification of Qualified Equity Investments Eligible for Kentucky New Markets Development Program Tax Credit", shall be used by a qualified community development entity that seeks to have an equity investment or long-term debt security certified as a qualified equity investment eligible for the tax credit provided by KRS 141.434.

(87)[(81)] Revenue Form 41A720-S81, "Form 8874(K)-A, Notice of Kentucky New Markets Development Program Tax Credit and Certification", shall be used by a qualified community development entity to provide proof to the Kentucky Department of Revenue of the receipt of cash for a taxpayer's qualified equity investment.

(88)[(82)] Revenue Form 41A720-S82, "Form 8874(K)-B, Notice of Kentucky New Markets Development Program Tax Credit Recapture", shall be used by the Kentucky Department of Revenue to notify a taxpayer of a recapture of the New Markets Development Program tax credit.

(89)[(83)] Revenue Form 41A725, "Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", shall be used by a single member individually-owned LLC to file an LLET return in accordance with KRS 141.0401 for tax years beginning in 2013[2012].

(90)[(84)] Revenue Form 41A725CP, "Schedule CP, Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned Composite Return Schedule", shall be used by a single member individual with multiple LLC entities to file LLET returns in accordance with KRS 141.0401 for tax years beginning in 2013[2012].

(91)[(85)] Revenue Form 41A725(I), "Instructions, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", shall be used by a single member LLC individually owned to file its 2013[2012] Kentucky LLET return and related schedules.

(92)[(86)] Revenue Form 41A750, "Form 750, Business Development Corporation Tax Return", shall be used by a corporation organized under the provisions of KRS Chapter 155 to determine its excise tax due in accordance with KRS 155.170 for tax years beginning in 2013[2012].

(93)[(87)] Revenue Form 41A765, "Form 765, 2013[2012] Kentucky Partnership Income and LLET Return", shall be used by an entity taxed as a partnership and organized as a LLC, LLP or LP to file its Kentucky income and LLET return in accordance with KRS 141.0401 and 141.206 for tax years beginning in 2013[2012].

(94)[(88)] Revenue Form 41A765(I), "Instructions, 2013[2012] Kentucky Partnership Income and LLET Return", shall be used by an entity taxed as a partnership and organized as a LLC, LLP, or LP to file its 2013[2012] Kentucky income and LLET return and related schedules.

(95)[(89)] Revenue Form 41A765(K), "Form 765(K), Kentucky Schedule K For Partnerships With Economic Development Project(s)", shall be used for tax years beginning in 2013[2012] by partnerships with economic development projects to determine the partners' share of income, credits, deductions, etc., excluding the economic development projects.

(96)[(90)] Revenue Form 41A765(K-1), "Schedule K-1 (Form 765), 2013[2012] Partner's Share of Income, Credits, Deductions, Etc.", shall be used by an entity taxed as a partnership and organized as a LLC, LLP, or LP to report to its partners the amount of income, credit, deduction, etc., that the partners shall report for Kentucky income tax purposes.

(97)[(91)] Revenue Form 41A800, "Corporation and Pass-

through Entity Nexus Questionnaire", shall be used by a corporation or pass-through entity to determine if the entity has nexus with the Commonwealth of Kentucky.

(98)[(92)] Revenue Form 41A802, "Corporation and Pass-through Entity Related Party Expense Questionnaire", shall be used by a corporation or pass-through entity to determine if the entity has nondeductible related party expense.

Section 2. Individual Income and Withholding Taxes. (1) Revenue Form 12A200, "Kentucky Individual Income Tax Installment Agreement Request", shall be submitted to the Department of Revenue to request an installment agreement to pay tax due.

(2) Revenue Form 40A100, "Application for Refund of Income Taxes", shall be presented to the Department of Revenue to request a refund of income taxes paid.

(3) Revenue Form 40A102, "2013[2012] Application for Extension of Time to File Individual, General Partnership and Fiduciary Income Tax Returns for Kentucky", shall be submitted to the Department of Revenue by individuals, partnerships, and fiduciaries prior to the date prescribed by law for filing a return to request a six (6) month extension to file the return or to remit payment of tax prior to the date the return is due.

(4) Revenue Form 40A103, "Application for New Home Tax Credit", shall be submitted to the Department of Revenue by individuals to request approval for the new home tax credit.

(5) Revenue Form 40A200, "Form PTE-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income", shall be used by a pass-through entity doing business in Kentucky to report Kentucky income tax withheld on each nonresident individual or corporate partner doing business in Kentucky only through its ownership interest in the pass-through entity.

(6) Revenue Form 40A201, "Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return", shall be used by a pass-through entity doing business in Kentucky to report and pay Kentucky income tax withheld on nonresident individual and corporate partners.

(7) Revenue Form 40A201ES, "Form 740NP-WH-ES, Instructions – 2014[2013] Pass-Through Entity Nonresident Distributive Share Withholding Report and Composite Income Tax Return Voucher", shall be used by every pass-through entity for the declaration and payment of estimated tax if required.

(8) Revenue Form 40A201NP-WH-SL, "Form 740NP-WH-SL, Application for Six-Month Extension of Time to File Form 740NP-WH", shall be used by a pass-through entity to request a six (6)-month extension to file Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return.

(9) Revenue Form 40A201-WHP, "Form 740NP-WH-P, Underpayment and Late Payment of Estimated Tax on Form 740NP-WH", shall be used by a pass-through entity to compute the interest and penalty on the underpayment and late payment of estimated tax on Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return.

(10) Revenue Form 40A727, "Kentucky Income Tax Forms Requisition", shall be used by a taxpayer or tax preparer to order individual income tax forms.

(11) Revenue Form 42A003, "Withholding Kentucky Income Tax Instructions for Employers", shall provide instructions for employers and shall contain forms used for withholding and reporting Kentucky income tax withholding.

(12) Revenue Form 42A003(T), "2014[2013] Withholding Tax Tables Computer Formula", shall be used by an employer for computing employees' Kentucky income tax withholding each pay period.

(13) Revenue Form 42A740, "Form 740, 2013[2012] Kentucky Individual Income Tax Return, Full-Year Residents Only", shall be completed by a resident individual to report taxable income and income tax liability for taxable years beginning in 2013[2012], and shall be due within three and one-half (3 1/2) months after the

close of the taxable year.

(14) Revenue Form 42A740-A, "Schedule A, Form 740, 2013[2012] Kentucky Itemized Deductions", shall be completed by resident individuals and attached to Form 740 to support itemized deductions claimed for 2013[2012].

(15) Revenue Form 42A740ES, "Form 740-ES, 2014[2013] Individual Income Tax Kentucky Estimated Tax Voucher", shall be submitted to the Department of Revenue by individuals with payment of quarterly estimated tax.

(16) Revenue Form 42A740-EZ, "Form 740-EZ, 2013[2012] Kentucky Individual Income Tax Return for Single Persons with No Dependents", shall be completed by resident individuals to report taxable income and income tax liability for taxable years beginning in 2013[2012], and shall be due within three and one-half (3 1/2) months after the close of the taxable year.

(17) Revenue Form 42A740(I), "2013[2012] Kentucky Individual Income Tax Instructions for Forms 740 and 740-EZ", shall be used by resident individuals to file the 2013[2012] Kentucky Individual Tax Return and related schedules.

(18) Revenue Form 42A740-J, "Schedule J, Kentucky Farm Income Averaging", shall be completed by individuals and attached to Form 740 to compute tax liability by averaging farm income for taxable years beginning after December 31, 1997.

(19) Revenue Form 42A740-KNOL, "Schedule KNOL, 2013[2012] Kentucky Net Operating Loss Schedule", shall be used by individuals to compute and carry forward a net operating loss to subsequent years.

(20) Revenue Form 42A740-M, "Schedule M, 2013[2012] Kentucky Federal Adjusted Gross Income Modifications", shall be completed by individuals and attached to Form 740 in support of additions to and subtractions from federal adjusted gross income.

(21) Revenue Form 42A740-NP, "Form 740-NP, 2013[2012] Kentucky Individual Income Tax Return, Nonresident or Part-Year Resident", shall be completed by part-year or full-year nonresident individuals to report taxable income and income tax liability for taxable years beginning in 2013[2012], and shall be filed within three and one-half (3 1/2) months after the close of the taxable year.

(22) Revenue Form 42A740-NP-A, "Schedule A, Form 740-NP, 2013[2012] Kentucky Schedule A Itemized Deductions", shall be completed and attached to Form 42A740-NP by part-year or full-year nonresidents to support the itemized deductions claimed for 2013[2012].

(23) Revenue Form 42A740-NP-ME, "Schedule ME, Form 740-NP, 2013[2012] Moving Expense and Reimbursement", shall be completed and attached to Form 42A740-NP by part-year or full-year nonresidents to support moving expenses and reimbursement by employers for moving expenses for 2013[2012].

(24) Revenue Form 42A740-NP(I), "Instructions for 2013[2012] Kentucky Form 740-NP, Nonresident or Part-Year Resident Income Tax Return", shall be used by nonresident or part-year resident individuals to file the 2013[2012] Kentucky Form 740-NP and related schedules.

(25) Revenue Form 42A740-NP-R, "Form 740-NP-R, 2013[2012] Kentucky Income Tax Return Nonresident - Reciprocal State", shall be completed by resident individuals of reciprocal states to request a refund of Kentucky withholding for 2013[2012].

(26) Revenue Form 42A740-NP(P), "2013[2012] Kentucky Income Tax Return, Nonresident or Part-Year Resident", shall be a packet containing forms and instructions and shall be mailed to nonresident and part-year resident individuals for use in filing a Kentucky individual tax return for 2013[2012].

(27) Revenue Form 42A740(PKT), "2013[2012] Kentucky Individual Income Tax Forms", shall be a packet containing forms and instructions and shall be mailed to resident individuals for use in filing a Kentucky individual tax return for 2013[2012].

(28) Revenue Form 42A740-P, "Schedule P, 2013[2012] Kentucky Pension Income Exclusion", shall be completed by individuals and attached to Form 740 to compute the amount of allowable pension exclusion for 2013[2012].

(29) Revenue Form 42A740-UTC, "Schedule UTC, Unemployment Tax Credit", shall be completed by individuals and attached to Form 740 or Form 740-NP to provide the Office of

Employment and Training Certificate Numbers in support of credit claimed for hiring an unemployed person.

(30) Revenue Form 42A740-X, "Form 740-X, Amended Kentucky Individual Income Tax Return", shall be completed by individuals and filed with the Department of Revenue to amend a previously filed tax return for 2005 or future years.

(31) Revenue Form 42A740-XP, "Form 740-XP, Amended Kentucky Individual Income Tax Return, 2004 and Prior Years", shall be completed by individuals and filed with the Department of Revenue to amend a previously filed tax return for 2004 or prior years.

(32) Revenue Form 42A740-S1, "Form 2210-K, 2013[2012] Underpayment of Estimated Tax by Individuals", shall be filed by individuals to request a waiver of estimated tax penalty or to compute and self assess an estimated tax penalty for a tax year beginning in 2013[2012].

(33) Revenue Form 42A740-S4, "2014[2013] Instructions for Filing Estimated Tax Vouchers", shall be used to compute the amount of estimated tax due for 2014[2013].

(34) Revenue Form 42A740-S18, "Form 8582-K, 2013[2012] Kentucky Passive Activity Loss Limitations", shall be completed by an individual taxpayer and attached to the individual tax return in support of an allowable passive loss deduction and carryover of a passive activity loss.

(35) Revenue Form 42A740-S21, "Form 4972-K, 2013[2012] Kentucky Tax on Lump-Sum Distributions", shall be completed by an individual taxpayer to compute tax liability on a lump sum distribution and attached to the taxpayer's individual income tax return.

(36) Revenue Form 42A740-S22, "Form 8879-K, 2013[2012] Kentucky Individual Income Tax Declaration for Electronic Filing", shall be completed, signed by the individual taxpayer or taxpayers and maintained by the preparer or taxpayer in support of an electronically filed return.

(37) Revenue Form 42A740-S23, "Form 740-V, 2013[2012] Kentucky Electronic Payment Voucher", shall be used by the individual taxpayer or taxpayers for the payment of additional tax due on an electronically filed return and submitted to the Department of Revenue.

(38) Revenue Form 42A740-S24, "Form 8863-K, 2013[2012] Kentucky Education Tuition Tax Credit", shall be used by an individual taxpayer or taxpayers to claim a tuition tax credit on the taxpayer's individual Kentucky income tax return.

(39) Revenue Form 42A740-S25, "Form 8948-K, Preparer Explanation For Not Filing Electronically", shall be used by the preparer to indicate the reason the return is not being filed electronically.

(40) Revenue Form 42A741, "Form 741, 2013[2012] Kentucky Fiduciary Income Tax Return", shall be used by a fiduciary of an estate or trust to report income and tax liability of an estate or trust and be filed with the Department of Revenue within three (3) months and fifteen (15) days after the close of the taxable year.

(41) Revenue Form 42A741-D, "Schedule D, Form 741, 2013[2012] Kentucky Capital Gains and Losses", shall be completed and attached to Form 741 by a fiduciary to report income from capital gains and losses.

(42) Revenue Form 42A741(I), "Instructions - Form 741, Kentucky Fiduciary Income Tax Return", shall be the instruction guide provided by the Department of Revenue for completing the 2013[2012] Form 741.

(43) Revenue Form 42A741(K-1), "Schedule K-1, Form 741, 2013[2012] Kentucky Beneficiary's Share of Income, Deductions, Credits, etc.", shall be filed by the fiduciary with Form 741 to report each beneficiary's share of income, deductions, and credits.

(44) Revenue Form 42A765-GP, "Form 765-GP, 2013[2012] Kentucky General Partnership Income Return", shall be completed and filed with the Department of Revenue within three (3) months and fifteen (15) days after the close of the taxable year by a general partnership to report income, deductions, and credits of a general partnership for 2013[2012].

(45) Revenue Form 42A765-GP(I), "Instructions, 2013[2012] Kentucky General Partnership Income Return", shall be provided to assist the general partnership in completing a general partnership

income return.

(46) Revenue Form 765-GP(K-1), "Schedule K-1, Form 765-GP, 2013[2012] Partner's Share of Income, Credits, Deductions, etc.", shall be filed by the general partnership with Form 765-GP to report each general partner's share of income, deductions, and credits.

(47) Revenue Form 42A765-GP(K), "Form 765-GP(K), Kentucky Schedule K for General Partnerships with Economic Development Project(s)", shall be used by a general partnership which has one (1) or more economic development projects to determine the total general partners' share of income, credits, deductions, etc., excluding the amount of each item of income, credit, deduction, etc., attributable to the projects.

(48) Revenue Form 42A801, "Form K-1, Kentucky Employer's Income Tax Withheld Worksheet", shall be used by employers to report wages and taxes withheld for the filing period.

(49) Revenue Form 42A801(D), "Form K-1, Amended Employer's Return of Income Tax Withheld", shall be used by employers to correct wages and taxes reported for the filing period.

(50) Revenue Form 42A801-E, "Form K-1E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", shall be used by employers who remit taxes withheld electronically to report wages and tax withheld for the filing period.

(51) "Form W-2, 2013[2012] Wage and Tax Statement", shall be used by an employer to report each of its employees' wages and Kentucky tax withheld for the calendar year 2013[2012].

(52) Revenue Form 42A803, "Form K-3, Kentucky Employer's Income Tax Withheld Worksheet", shall be used by employers to report wages and tax withheld for the filing period and annually reconcile wages and taxes reported.

(53) Revenue Form 42A803(D), "Form K-3, Amended Employer's Return of Income Tax Withheld", shall be used by employers to amend wages and taxes reported for the filing period and the annual reconciled wages and taxes reported.

(54) Revenue Form 42A803-E, "Form K-3E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", shall be used by employers to report wages and tax withheld for the filing period and to annually reconcile wages and taxes reported.

(55) Revenue Form 42A804, "Form K-4, Kentucky Department of Revenue Employee's Withholding Exemption Certificate", shall be used by an employee to inform the employer of the number of exemptions claimed in order to determine the amount of Kentucky tax to withhold from wages each pay period.

(56) Revenue Form 42A804-A, "Form K-4A, Kentucky Department of Revenue Withholding Exemptions for Excess Itemized Deductions", shall be used by an employee to determine additional withholding exemptions.

(57) Revenue Form 42A804-E, "Form K-4E, Special Withholding Exemption Certificate", shall be used by employees to inform employers of special tax exempt status.

(58) Revenue Form 42A804-M, "Form K-4M, Nonresident Military Spouse Withholding Tax Exemption Certificate", shall be used by employees to inform employers of special tax exempt status as a nonresident military spouse.

(59) Revenue Form 42A806, "Transmitter Report for Filing Kentucky W2/K2, 1099 and W2-G Statements", shall be used by employers annually to submit Form W-2 Wage and Tax Statements.

(60) Revenue Form 42A807, "Form K-4FC, Fort Campbell Exemption Certificate", shall be completed by nonresident employees working at Fort Campbell, Kentucky, to inform employers of special tax exempt status.

(61) Revenue Form 42A808, "Authorization to Submit Employees Annual Wage and Tax Statements Via Kentucky Department of Revenue Web Site", shall be used by employers to request authorization to annually submit wage and tax statements via the Kentucky Department of Revenue Web site.

(62) Revenue Form 42A809, "Certificate of Nonresidence", shall be used by employees to inform employers of special tax exempt status as a result of being a resident of a reciprocal state.

(63) Revenue Form 42A810, "Nonresident's Affidavit - Kentucky Individual Income Tax", shall be used by individuals to

submit a sworn statement concerning residency status.

(64) Revenue Form 42A811, "KREDA Annual Report", shall be completed by employers to report KREDA employee wage assessment fee information to the Department of Revenue.

(65) Revenue Form 42A812, "KIDA Annual Report", shall be completed by employers to report KIDA employee wage assessment fee information to the Department of Revenue.

(66) Revenue Form 42A813, "KJDA Annual Report", shall be completed by employers to report KJDA employee wage assessment fee information to the Department of Revenue.

(67) Revenue Form 42A814, "KIRA Annual Report", shall be completed by employers to report KIRA employee wage assessment fee information to the Department of Revenue.

(68) Revenue Form 42A815, "Withholding Tax Refund Application", shall be completed by employers to request a refund of withholding tax paid.

(69) Revenue Form 42A816, "KEOZ Annual Report", shall be completed by employers to report KEOZ employee wage assessment fee information to the Department of Revenue.

(70) Revenue Form 42A817, "KJRA Annual Report", shall be completed by employers to report KJRA employee wage assessment fee information to the Department of Revenue.

(71) Revenue Form 42A818, "KBI Annual Report", shall be completed by employers to report KBI employee wage assessment fee information to the Department of Revenue.

(72) Revenue Form 42D003, "2013[2012] Kentucky Wage and Tax Statements (W-2/K-2) Order Form", shall be used by employers to order wage and tax statements.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Corporation income taxes - referenced material:

1. Revenue Form 41A720, "Form 720, 2013[2012] Kentucky Corporation Income Tax and LLET Return", 2013[2012];

2. Revenue Form 41A720A, "Schedule A, Apportionment and Allocation (For corporations and pass-through entities taxable both within and without Kentucky)", October 2013[2012];

3. Revenue Form 41A720A-C, "Schedule A-C, Apportionment and Allocation - Continuation Sheet", October 2013[2012];

4. Revenue Form 41A720A-N, "Schedule A-N, Apportionment Factor Schedule", October 2013[2012];

5. Revenue Form 41A720BIO, "Schedule BIO, Application and Credit Certificate of Income Tax/LLET Credit Biodiesel", October 2013[2012];

6. Revenue Form 41A720CC, "Schedule CC, Coal Conversion Tax Credit", October 2013[2012];

7. Revenue Form 41A720CCI, "Schedule CCI, Application and Credit Certificate of Clean Coal Incentive Tax Credit", October 2013[2012];

8. Revenue Form 41A720CELL, "Schedule CELL, Application and Credit Certificate of Income Tax/LLET Credit Cellulosic Ethanol", October 2013[2012];

9. Revenue Form 41A720CI, "Schedule CI, Application for Coal Incentive Tax Credit", October 2013[2012];

10. Revenue Form 41A720COGS, "Schedule COGS, Limited Liability Entity Tax Cost of Goods Sold", October 2013;

11. Revenue Form 41A720CR, "Schedule CR, Pro Forma Federal Consolidated Return Schedule", October 2013[2012];

12.[11-] Revenue Form 41A720CR-C, "Schedule CR-C, Pro Forma Federal Consolidated Return Schedule Continuation Sheet", October 2013[2012];

13.[12-] Revenue Form 41A720ES, "Form 720-ES Kentucky, 2014[2013] Corporation Income/Limited Liability Entity Tax Estimated Tax Voucher", June 2013[2012];

14.[13-] Revenue Form 41A720ETH, "Schedule ETH, Application and Credit Certificate of Income Tax/LLET Credit Ethanol", October 2013[2012]; [14- Revenue Form 41A720EZC, "Schedule EZC, Enterprise Zone Tax Credit", October 2012-]

15. Revenue Form 41A720FD, "Schedule FD, Food Donation Tax Credit", October 2013;

16. Revenue Form 41A720HH, "Schedule HH, Kentucky Housing for Homeless Families Deduction", October 2013[2012];

17.[16-] Revenue Form 41A720(I), "Instructions, 2013[2012]

Kentucky Corporation Income Tax and LLET Return", November 2013[2012];

18.[17-] Revenue Form 41A720KCR, "Schedule KCR, Kentucky Consolidated Return Schedule", October 2013[2012];

19.[18-] Revenue Form 41A720KCR-C, "Schedule KCR-C, Kentucky Consolidated Return Schedule - Continuation Sheet", October 2013[2012];

20.[19-] Revenue Form 41A720KESA, "Schedule KESA, Tax Credit Computation Schedule (For a KESA Project of a Corporation)", October 2013[2012];

21.[20-] Revenue Form 41A720KESA-SP, "Schedule KESA-SP, Tax Credit Computation Schedule (For a KESA Project of a Pass-Through Entity)", October 2013[2012];

22.[21-] Revenue Form 41A720KESA-T, "Schedule KESA-T, Tracking Schedule for a KESA Project", October 2013[2012];

23.[22-] Revenue Form 41A720LLET, "Schedule LLET, Limited Liability Entity Tax", October 2013[2012];

24.[23-] Revenue Form 41A720LLET-C, "Schedule LLET-C, Limited Liability Entity Tax - Continuation Sheet", October 2013[2012];

25.[24-] Revenue Form 41A720LLET(K), "Schedule LLET(K), Limited Liability Entity Tax (For a Limited Liability Pass-through Entity with Economic Development Project(s))", October 2013[2012];

26.[25-] Revenue Form 41A720LLET(K)-C, "Schedule LLET(K)-C, Limited Liability Entity Tax - Continuation Sheet", October 2013[2012];

27.[26-] Revenue Form 41A720NOL, "Schedule NOL, Net Operating Loss Schedule", October 2013[2012];

28.[27-] Revenue Form 41A720NOL-CF, "Schedule NOL-CF, Kentucky NOL Carry forward Schedule", October 2013[2012];

29.[28-] Revenue Form 41A720-O, "Schedule O-720, Other Additions and Subtractions To/From Federal Taxable Income", December 2013[2012];

30.[29-] Revenue Form 41A720QR, "Schedule QR, Qualified Research Facility Tax Credit", October 2013[2012];

31.[30-] Revenue Form 41A720RC, "Schedule RC, Application for Income Tax/LLET Credit for Recycling and/or Composting Equipment or Major Recycling Project", October 2013[2012];

32.[31-] Revenue Form 41A720RC-C, "Schedule RC-C, Schedule RC - Part I Continuation", October 2013[2012];

33.[32-] Revenue Form 41A720RC(I), "Instructions For Schedule RC", October 2013[2012];

34.[33-] Revenue Form 41A720RC-R, "Schedule RC-R, Recycling or Composting Equipment Tax Credit Recapture", October 2013[2012];

35.[34-] Revenue Form 41A720RPC, "Schedule RPC, Related Party Costs Disclosure Statement", June 2013[2012];

36.[35-] Revenue Form 41A720RR-E, "Schedule RR-E, Application and Credit Certificate of Income Tax/LLET Credit Railroad Expansion", October 2013[2012];

37.[36-] Revenue Form 41A720RR-I, "Schedule RR-I, Railroad Maintenance and Improvement Tax Credit", October 2013[2012];

38.[37-] Revenue Form 41A720S, "Form 720S, 2013[2012] Kentucky S Corporation Income Tax and LLET Return", 2013[2012];

39.[38-] Revenue Form 41A720S(I), "Instructions, 2013[2012] Kentucky S Corporation Income Tax and LLET Return", November 2013[2012];

40.[39-] Revenue Form 41A720S(K), "Form 720S(K), Kentucky Schedule K for S Corporations With Economic Development Project(s)", October 2013[2012];

41.[40-] Revenue Form 41A720S(K-1), "Schedule K-1 (Form 720S), 2013[2012] Shareholder's Share of Income, Credits, Deductions, Etc.", 2013[2012];

42.[41-] Revenue Form 41A720S-O, "Schedule O-PTE, Other Additions and Subtractions To/From Federal Ordinary Income", November 2013[2012];

43.[42-] Revenue Form 41A720SL, "Application for Six-Month Extension of Time to File Kentucky Corporation or Limited Liability Pass-Through Entity Return", June 2013[2012];

44.[43-] Revenue Form 41A720TCS, "Schedule TCS, Tax Credit Summary Schedule", October 2013[2012];

45.[44.] Revenue Form 41A720VERB, "Schedule VERB, Voluntary Environmental Remediation Tax Credit", October 2013[2012];

46.[45.] Revenue Form 41A720-S1, "Form 720X, Amended Kentucky Corporation Income Tax and Corporation License Tax Return", October 2011;

47.[46.] Revenue Form 41A720-S2, "Form 720-AMENDED, Amended Kentucky Corporation Income Tax Return", October 2011;

48.[47.] Revenue Form 41A720-S3, "Form 720-AMENDED (2007-2008), Amended Kentucky Corporation Income Tax and LLET Return", October 2011;

49.[48.] Revenue Form 41A720-S4, "Form 851-K, Kentucky Affiliations and Payment Schedule", October 2013[2012];

50.[49.] Revenue Form 41A720-S6, "Form 2220-K, Underpayment and Late Payment of Estimated Income Tax and LLET", October 2013[2012];

51.[50.] Revenue Form 41A720-S7, "Form 5695-K, Kentucky Energy Efficiency Products Tax Credit", October 2013[2012];

52. Revenue Form 41A720-S8, "Form 8879(C) – K, Kentucky Corporation or Pass-Through Entity Tax Return Declaration for Electronic Filing", October 2013;

53.[51.] Revenue Form 41A720-S9, "Schedule 8903-K, Kentucky Domestic Production Activities Deduction", October 2013[2012];

54.[52.] Revenue Form 41A720-S11, "Form 8908-K, Kentucky ENERGY STAR (Homes and Manufactured Homes) Tax Credit", October 2013[2012];

55. Revenue Form 41A720-S12, "720-V, Electronic Filing Payment Voucher", October 2013;

56.[53.] Revenue Form 41A720-S16, "Schedule KREDA, Tax Credit Computation Schedule (For a KREDA Project of a Corporation)", October 2013[2012];

57.[54.] Revenue Form 41A720-S17, "Schedule KREDA-T, Tracking Schedule for a KREDA Project", October 2013[2012];

58.[55.] Revenue Form 41A720-S18, "Schedule KREDA-SP, Tax Computation Schedule (For a KREDA Project of a Pass-Through Entity)", October 2013[2012];

59.[56.] Revenue Form 41A720-S20, "Schedule KIDA, Tax Credit Computation Schedule (For a KIDA Project of a Corporation)", October 2013[2012];

60.[57.] Revenue Form 41A720-S21, "Schedule KIDA-T, Tracking Schedule for a KIDA Project" October 2013[2012];

61.[58.] Revenue Form 41A720-S22, "Schedule KIDA-SP, Tax Computation Schedule (For a KIDA Project of a Pass-Through Entity)", October 2013[2012];

62.[59.] Revenue Form 41A720-S24, "Schedule KIRA, Tax Credit Computation Schedule (For a KIRA Project of a Corporation)", October 2013[2012];

63.[60.] Revenue Form 41A720-S25, "Schedule KIRA-T, Tracking Schedule for a KIRA Project", October 2013[2012];

64.[61.] Revenue Form 41A720-S26, "Schedule KIRA-SP, Tax Computation Schedule (For a KIRA Project of a Pass-Through Entity)", October 2013[2012];

65.[62.] Revenue Form 41A720-S27, "Schedule KJDA, Tax Credit Computation Schedule (For a KJDA Project of a Corporation)", October 2013[2012];

66.[63.] Revenue Form 41A720-S28, "Schedule KJDA-T, Tracking Schedule for a KJDA Project", October 2013[2012];

67.[64.] Revenue Form 41A720-S29, "Schedule KJDA-SP, Tax Computation Schedule (For a KJDA Project of a Pass-Through Entity)", October 2013[2012];

68.[65.] Revenue Form 41A720-S35, "Schedule KRA, Tax Credit Computation Schedule (For a KRA Project of a Corporation)", October 2013[2012];

69.[66.] Revenue Form 41A720-S36, "Schedule KRA-SP, Tax Computation Schedule (For a KRA Project of a Pass-Through Entity)", October 2013[2012];

70.[67.] Revenue Form 41A720-S37, "Schedule KRA-T, Tracking Schedule for a KRA Project", October 2013[2012];

71.[68.] Revenue Form 41A720-S40, "Schedule KEOZ, Tax Credit Computation Schedule (For a KEOZ Project of a Corporation)", October 2013[2012];

72.[69.] Revenue Form 41A720-S41, "Schedule KEOZ-SP, Tax Computation Schedule (For a KEOZ Project of a Pass-Through Entity)", October 2013[2012];

73.[70.] Revenue Form 41A720-S42, "Schedule KEOZ-T, Tracking Schedule for a KEOZ Project", October 2013[2012];

74.[71.] Revenue Form 41A720-S45, "Schedule KJRA, Tax Credit Computation Schedule (For a KJRA Project of a Corporation)", October 2013[2012];

75.[72.] Revenue Form 41A720-S46, "Schedule KJRA-T, Tracking Schedule for a KJRA Project", October 2013[2012];

76.[73.] Revenue Form 41A720-S47, "Schedule KJRA-SP, Tax Computation Schedule (For a KJRA Project of a Pass-Through Entity)", October 2013[2012];

77.[74.] Revenue Form 41A720-S50, "Schedule IEIA, Tax Credit Computation Schedule (For an IEIA Project of a Corporation)", October 2013[2012];

78.[75.] Revenue Form 41A720-S51, "Schedule IEIA-T, Tracking Schedule for an IEIA Project", October 2013[2012];

79.[76.] Revenue Form 41A720-S52, "Schedule IEIA-SP, Tax Computation Schedule (For an IEIA Project of a Pass-Through Entity)", October 2013[2012];

80.[77.] Revenue Form 41A720-S53, "Schedule KBI, Tax Credit Computation Schedule (For a KBI Project of a Corporation)", October 2013[2012];

81.[78.] Revenue Form 41A720-S54, "Schedule KBI-SP, Tax Computation Schedule (For a KBI Project of a Pass-Through Entity)", October 2013[2012];

82.[79.] Revenue Form 41A720-S55, "Schedule KBI-T, Tracking Schedule for a KBI Project", October 2013[2012];

83. Revenue Form 41A720-S56, "Schedule FON, Tax Credit Computation Schedule (For a FON project of a corporation)", October 2013;

84. Revenue Form 41A720-S57, "Schedule FON-SP, Tax Computation Schedule (For a FON project of a Pass-Through Entity)", October 2013;

85. Revenue Form 41A720-S58, "Schedule FON-T, Tracking Schedule for a FON project", October 2013;

86.[80.] Revenue Form 41A720-S80, "Form 8874(K), Application for Certification of Qualified Equity Investments Eligible for Kentucky New Markets Development Program Tax Credit", June 2010;

87.[81.] Revenue Form 41A720-S81, "Form 8874(K)-A, Notice of Kentucky New Markets Development Program Tax Credit and Certification", June 2013[2012];

88.[82.] Revenue Form 41A720-S82, "Form 8874(K)-B, Notice of Kentucky New Markets Development Program Tax Credit Recapture", June 2013[2012];

89.[83.] Revenue Form 41A725, "Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", 2013[2012];

90.[84.] Revenue Form 41A725CP, "Schedule CP, Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned Composite Return Schedule", 2013[2012];

91.[85.] Revenue Form 41A725(I), "Instructions, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", October 2013[2012];

92.[86.] Revenue Form 41A750, "Form 750, Business Development Corporation Tax Return", September 2013[2012];

93.[87.] Revenue Form 41A765, "Form 765, 2013[2012] Kentucky Partnership Income and LLET Return", 2013[2012];

94.[88.] Revenue Form 41A765(I), "Instructions, 2013[2012] Kentucky Partnership Income and LLET Return", November 2013[2012];

95.[89.] Revenue Form 41A765(K), "Form 765(K), Kentucky Schedule K For Partnerships With Economic Development Project(s)", October 2013[2012];

96.[90.] Revenue Form 41A765(K-1), "Schedule K-1 (Form 765), 2013[2012] Partner's Share of Income, Credits, Deductions, Etc.", 2013[2012];

97.[91.] Revenue Form 41A800, "Corporation and Pass-through Entity Nexus Questionnaire", December 2013[2014]; and

98.[92.] Revenue Form 41A802, "Corporation and Pass-through Entity Related Party Expense Questionnaire", June

2013[October 2012]; and

(b) Individual income and withholding taxes - referenced material:

1. Revenue Form 12A200, "Kentucky Individual Income Tax Installment Agreement Request", November 2013[2012];
2. Revenue Form 40A100, "Application for Refund of Income Taxes", October 2013[2012];
3. Revenue Form 40A102, "2013[2012] Application for Extension of Time to File Individual, General Partnership and Fiduciary Income Tax Returns for Kentucky", November 2013[2012];
4. Revenue Form 40A103, "Application for New Home Tax Credit", June 2010;
5. Revenue Form 40A200, "Form PTE-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income", October 2013[2012];
6. Revenue Form 40A201, "Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return", October 2013[2012];
7. Revenue Form 40A201ES, "Form 740NP-WH-ES, Instructions – 2014[2013] Pass-Through Entity Nonresident Distributive Share Withholding Report and Composite Income Tax Return Voucher", October 2013[2012];
8. Revenue Form 40A201NP-WH-SL, "Form 740NP-WH-SL, Application for Six-Month Extension of Time to File Form 740NP-WH", October 2013[2012];
9. Revenue Form 40A201-WHP, "Form 740NP-WH-P, Underpayment and Late Payment of Estimated Tax on Form 740NP-WH", October 2013[2012];
10. Revenue Form 40A727, "Kentucky Income Tax Forms Requisition", October 2013[2012];
11. Revenue Form 42A003, "Withholding Kentucky Income Tax Instructions for Employers", August 2011;
12. Revenue Form 42A003(T), "2014[2013] Withholding Tax Tables Computer Formula", September 2013[2012];
13. Revenue Form 42A740, "Form 740, 2013[2012] Kentucky Individual Income Tax Return, Full-Year Residents Only", 2013[2012];
14. Revenue Form 42A740-A, "Schedule A, Form 740, 2013[2012] Kentucky Itemized Deductions", 2013[2012];
15. Revenue Form 42A740ES, "Form 740-ES, 2014[2013] Individual Income Tax Kentucky Estimated Tax Voucher", September 2013[June 2012];
16. Revenue Form 42A740-EZ, "Form 740-EZ, 2013[2012] Kentucky Individual Income Tax Return for Single Persons with No Dependents", 2013[2012];
17. Revenue Form 42A740(I), "2013[2012] Kentucky Individual Income Tax Instructions for Forms 740 and 740-EZ", October 2013[2012];
18. Revenue Form 42A740-J, "Schedule J, Kentucky Farm Income Averaging", October 2013[2012];
19. Revenue Form 42A740-KNOL, "Schedule KNOL, 2013[2012] Kentucky Net Operating Loss Schedule", 2013[2012];
20. Revenue Form 42A740-M, "Schedule M, 2013[2012] Kentucky Federal Adjusted Gross Income Modifications", 2013[2012];
21. Revenue Form 42A740-NP, "Form 740-NP, 2013[2012] Kentucky Individual Income Tax Return, Nonresident or Part-Year Resident", 2013[2012];
22. Revenue Form 42A740-NP-A, "Schedule A, Form 740-NP, 2013[2012] Kentucky Schedule A Itemized Deductions", 2013[2012];
23. Revenue Form 42A740-NP-ME, "Schedule ME, Form 740-NP, 2013[2012] Moving Expense and Reimbursement", 2013[2012];
24. Revenue Form 42A740-NP(I), "Instructions for 2013[2012] Kentucky Form 740-NP, Nonresident or Part-Year Resident Income Tax Return", October 2013[2012];
25. Revenue Form 42A740-NP-R, "Form 740-NP-R, 2013[2012] Kentucky Income Tax Return Nonresident - Reciprocal State", 2013[2012];
26. Revenue Form 42A740-NP(P), "2013[2012] Kentucky Income Tax Return Nonresident or Part-Year Resident", October

2013[2012];

27. Revenue Form 42A740(PKT), "2013[2012] Kentucky Individual Income Tax Forms", October 2013[2012];
28. Revenue Form 42A740-P, "Schedule P, 2013[2012] Kentucky Pension Income Exclusion", 2013[2012];
29. Revenue Form 42A740-UTC, "Schedule UTC, Unemployment Tax Credit", October 2013[2012];
30. Revenue Form 42A740-X, "Form 740-X, Amended Kentucky Individual Income Tax Return", November 2013[2012];
31. Revenue Form 42A740-XP, "Form 740-XP, Amended Kentucky Individual Income Tax Return, 2004 and Prior Years", November 2008;
32. Revenue Form 42A740-S1, "Form 2210-K, 2013[2012] Underpayment of Estimated Tax by Individuals", 2013[2012];
33. Revenue Form 42A740-S4, "2014[2013] Instructions for Filing Estimated Tax Vouchers", October 2013[2012];
34. Revenue Form 42A740-S18, "Form 8582-K, 2013[2012] Kentucky Passive Activity Loss Limitations", 2013[2012];
35. Revenue Form 42A740-S21, "Form 4972-K, 2013[2012] Kentucky Tax on Lump-Sum Distributions", 2013[2012];
36. Revenue Form 42A740-S22, "Form 8879-K, 2013[2012] Kentucky Individual Income Tax Declaration for Electronic Filing", 2013[2012];
37. Revenue Form 42A740-S23, "Form 740-V, 2013[2012] Kentucky Electronic Payment Voucher", November 2013[2012];
38. Revenue Form 42A740-S24, "Form 8863-K, 2013[2012] Kentucky Education Tuition Tax Credit", 2013[2012];
39. Revenue Form 42A740-S25, "Form 8948-K, Preparer Explanation For Not Filing Electronically", October 2013[2012];
40. Revenue Form 42A741, "Form 741, 2013[2012] Kentucky Fiduciary Income Tax Return", 2013[2012];
41. Revenue Form 42A741-D, "Schedule D, Form 741, 2013[2012] Kentucky Capital Gains and Losses", 2013[2012];
42. Revenue Form 42A741(I), "Instructions - Form 741, Kentucky Fiduciary Income Tax Return", October 2013[2012];
43. Revenue Form 42A741(K-1), "Schedule K-1, Form 741, 2013[2012] Kentucky Beneficiary's Share of Income, Deductions, Credits, etc.", 2013[2012];
44. Revenue Form 42A765-GP, "Form 765-GP, 2013[2012] Kentucky General Partnership Income Return", 2013[2012];
45. Revenue Form 42A765-GP(I), "Instructions, 2013[2012] Kentucky General Partnership Income Return", November 2013[2012];
46. Revenue Form 765-GP(K-1), "Schedule K-1, Form 765-GP, 2013[2012] Partner's Share of Income, Credits, Deductions, etc.", 2013[2012];
47. Revenue Form 42A765-GP(K), "Form 765-GP(K), Kentucky Schedule K for General Partnerships with Economic Development Project(s)", October 2013[2012];
48. Revenue Form 42A801, "Form K-1, Kentucky Employer's Income Tax Withheld Worksheet", March 2007;
49. Revenue Form 42A801(D), "Form K-1, Amended Employer's Return of Income Tax Withheld", April 2008;
50. Revenue Form 42A801-E, "Form K-1E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", March 2007;
51. "Form W-2, 2013[2012] Wage and Tax Statement", 2013[2012];
52. Revenue Form 42A803, "Form K-3, Kentucky Employer's Income Tax Withheld Worksheet", March 2007;
53. Revenue Form 42A803(D), "Form K-3, Amended Employer's Return of Income Tax Withheld", April 2008;
54. Revenue Form 42A803-E, "Form K-3E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", March 2007;
55. Revenue Form 42A804, "Form K-4, Kentucky Department of Revenue Employee's Withholding Exemption Certificate", November 2013[2010];
56. Revenue Form 42A804-A, "Form K-4A, Kentucky Department of Revenue Withholding Exemptions for Excess Itemized Deductions", April 2008;
57. Revenue Form 42A804-E, "Form K-4E, Special Withholding Exemption Certificate", May 2013[March 2012];

58. Revenue Form 42A804-M, "Form K-4M, Nonresident Military Spouse Withholding Tax Exemption Certificate", November 2010;

59. Revenue Form 42A806, "Transmitter Report for Filing Kentucky W2/K2, 1099 and W2-G Statements", July 2013~~October 2011~~;

60. Revenue Form 42A807, "Form K-4FC, Fort Campbell Exemption Certificate", August 2006;

61. Revenue Form 42A808, "Authorization to Submit Employees Annual Wage and Tax Statements Via Kentucky Department of Revenue Web Site", March 2006;

62. Revenue Form 42A809, "Certificate of Nonresidence", March 2007;

63. Revenue Form 42A810, "Nonresident's Affidavit - Kentucky Individual Income Tax", April 1989;

64. Revenue Form 42A811, "KREDA Annual Report", December 2007;

65. Revenue Form 42A812, "KIDA Annual Report", December 2007;

66. Revenue Form 42A813, "KJDA Annual Report", December 2007;

67. Revenue Form 42A814, "KIRA Annual Report", December 2007;

68. Revenue Form 42A815, "Withholding Tax Refund Application", August 2006;

69. Revenue Form 42A816, "KEOZ Annual Report", December 2007;

70. Revenue Form 42A817, "KJRA Annual Report", October 2010;

71. Revenue Form 42A818, "KBI Annual Report", October 2010; and

72. Revenue Form 42D003, "2013~~2012~~ Kentucky Wage and Tax Statements (W-2/K-2) Order Form", August 2013~~July 2012~~.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 from 10:00 a.m. to 12:00 p.m., in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 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 February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Department of Revenue, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9826, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation prescribes the forms to be used when reporting and paying corporation income tax, limited liability entity tax, individual income tax for tax years beginning in 2013; withholding taxes for calendar year 2013; and installments of estimated tax for tax years beginning in 2014.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order to provide taxpayers necessary tax forms for reporting and paying their corporation income tax, limited liability entity tax, individual income tax for tax years beginning in 2013; withholding taxes for calendar year 2013; and installments of estimated tax for tax years beginning in 2014.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of any revenue law by the promulgation of an administrative regulation pursuant to KRS Chapter 13A incorporating forms by reference.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation prescribes forms to be used by taxpayers to report and pay corporation taxes, limited liability entity taxes, individual income taxes, and withholding taxes to the Commonwealth of Kentucky pursuant to KRS Chapter 141.

(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 contains income and limited liability entity tax forms to be used for tax years beginning in 2013, and estimated tax forms to be used for tax years beginning in 2014.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to update tax forms to the current tax laws in effect for years beginning in 2013.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of the tax laws.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide taxpayers with the necessary tax forms to file and pay income taxes, limited liability entity taxes, and individual withholding taxes for tax years beginning in 2013.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All individual, pass-through entity and corporate tax filers are affected by this 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: Individual, pass-through entity, and corporate tax filers will use the forms contained in this administrative regulation to report, pay, and withhold taxes due pursuant to KRS Chapter 141 for tax years beginning in 2013.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The cost of filing tax returns contained in this administrative regulation with the Commonwealth of Kentucky should be comparable to filing tax returns with surrounding states.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The forms contained in this administrative regulation should simplify and expedite the reporting and paying of taxes required by KRS Chapter 141.

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

(a) Initially: The cost of printing and designing the forms.

(b) On a continuing basis: Forms are updated each year.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Funds will be provided by the Department of Revenue.

(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 additional funding will be required 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 does not establish any fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied as the forms included in this administrative regulation apply to all taxpayers taxed pursuant to KRS Chapter 141.

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? Finance and Administration Cabinet, Department of Revenue.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS Chapter 131.130(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. This administrative regulation will not increase revenues or expenses for the Commonwealth, but will expedite the collection of taxes provided by KRS Chapter 141.

(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 collected as a result of this 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? None.

(c) How much will it cost to administer this program for the first year? A very small increase in expenditures will occur in the administrative regulation process that will be absorbed by the department operating budget.

(d) How much will it cost to administer this program for subsequent years? No costs 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:

STATEMENT OF EMERGENCY

109 KAR 16:010E

The Kentucky General Assembly directed the Department for Local Government to promulgate administrative regulations for the registration of special purpose governmental entities and for the reporting of certain financial information by such entities in KRS chapter 65A, which was enacted in 2013. This administrative regulation prescribes the forms, protocols, and other logistics necessary to implement the new law. The bill creating KRS Chapter 65A, HB1 of the 2013 regular session, declared an emergency and called for reporting by special purpose governmental entities as soon as possible. Although registration has begun, administrative regulations are required to give effect to certain provisions of the law. An ordinary administrative regulation alone will not cause the required policies and protocols to be adopted by the expedited statutory deadline. This administrative regulation is authorized to be filed as an emergency administrative regulation pursuant to KRS 13A.190(1)(a)(3). This emergency administrative regulation will be replaced by an ordinary administrative regulation. The ordinary administrative regulation is being filed with the Regulations Compiler simultaneously with this emergency administrative regulation. The ordinary administrative regulation is identical to this emergency administrative regulation.

HON. STEVEN L. BESHEAR, Governor
TONY WILDER, Commissioner

OFFICE OF THE GOVERNOR Department for Local Government (New Emergency Administrative Regulation)

109 KAR 16:010E. Special purpose governmental entities.

RELATES TO: KRS 65A.010, 65A.020, 65A.030, 65A.040, 65A.090

STATUTORY AUTHORITY: KRS 65A.020

EFFECTIVE: December 18, 2013

NECESSITY, FUNCTION, AND CONFORMITY: KRS 65A.020(3)(a) requires the Department for Local Government to promulgate administrative regulations to develop standard forms, protocols, timeframes, and due dates for the submission of information by special purpose governmental entities. This administrative regulation establishes the format for financial disclosure by special purpose governmental entities and prescribes the protocols, timeframes, and due dates for submission of information by special purpose governmental entities.

Section 1. Definitions. (1) "Annual revenue" means all revenue, from whatever source, received by the special purpose governmental entity during the most recent fiscal period for which data is available, as reflected in the budget to actual portion of DLG Form SPGE 101 required by Section 4(1) of this administrative regulation.

(2) "Budget" means the estimated revenues and appropriations for a fiscal period.

(3) "DLG" is defined by KRS 65A.010(2).

(4) "Fiscal period" means the fiscal year adopted by the special purpose governmental entity for budgeting purposes.

(5) "Registry" is defined by KRS 65A.010(7).

(6) "Special purpose governmental entity" or "SPGE" is defined by KRS 65A.010(8).

Section 2. Registration with the Department for Local Government. (1) All special purpose governmental entities in existence prior to December 31, 2013 shall, prior to December 31, 2013, complete and submit DLG Form SPGE 100 Special Purpose Governmental Entity Registration and Board Reporting Form. The information shall be submitted in the same manner as required by Section 3(1) of this administrative regulation. The DLG may allow an alternative form of submission as provided in Section 3(2) of this administrative regulation. This submission shall serve as the initial registration required by KRS 65A.090(1).

(2) A special purpose governmental entity established after December 31, 2013 shall complete and submit DLG Form SPGE 100 Special Purpose Governmental Entity Registration and Board Reporting Form within fifteen (15) days of the establishment of the entity. The form shall be submitted as provided in subsection (1) of this section.

Section 3. Electronic submission required; exceptions. (1) Except as provided by subsections (2) and (3) of this section, all information required to be submitted to the DLG shall be submitted electronically, using the information reporting portal on the DLG Web site at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm>.

(2) A special purpose governmental entity may request approval from the DLG to submit required information by alternative means. The request shall be in writing, and shall:

(a) State the name of the special purpose governmental entity;

(b) List all information for which an alternative means of submission is sought;

(c) Be made by the governing body of the special purpose governmental entity;

(d) Be received by the DLG at least sixty (60) days before the information to which the request relates is due;

(e) State the reason why the required information cannot be submitted using the standard electronic submission format; and

(f) Identify the method of submission proposed.

(3)(a) Approval of an alternative submission method shall be at the discretion of the DLG. If the DLG approves an alternative submission method, the special purpose governmental entity shall

submit the information in the form and format determined by the DLG and communicated to the special purpose governmental entity as part of the approval process.

(b) The DLG may withdraw approval to use an alternative reporting method at any time by providing written notice of the withdrawal of approval to the special purpose governmental entity at least thirty (30) days prior to the effective date of the withdrawal of approval.

Section 4. Requirements for Submission of Administrative and Financial Information. For each fiscal period beginning on or after July 1, 2014, each special purpose governmental entity shall annually submit information for publication on the registry as required by this section. (1) Within fifteen (15) days following the beginning of each fiscal period, the SPGE shall submit the administrative information required by KRS 65A.020(2)(a)1, using Section I of DLG Form SPGE 101.

(2) The SPGE shall submit the budget information required by KRS 65A.020(2)(a)1 using DLG Form SPGE 101 and shall submit the budget information as required by this subsection.

(a) Each special purpose governmental entity shall submit its adopted budget to the DLG within fifteen (15) days following the beginning of the fiscal period for which the adopted budget applies.

(b) Each special purpose governmental entity shall submit a comparison of the adopted budget to actual revenues and expenditures for each fiscal period within sixty (60) days following the close of each fiscal period.

(c) The comparison of the adopted budget to actual revenues and expenditures shall be reflected on the budget to actual portion of SPGE 101.

(3) Within fifteen (15) days following the beginning of each fiscal period, each SPGE shall submit the financial information required by KRS 65A.020(2)(a)2. This information shall be submitted using DLG Form SPGE 101 and shall list all taxes, fees, or charges imposed and collected by the entity, including the rates or amounts charged for the reporting period and the statutory authority for the levy of the tax, fee, or charge.

Section 5. Submission of Audits and Attestation Engagements.

(1) An audit or attestation engagement required to be submitted for publication on the registry pursuant to KRS 65A.030 shall be submitted to the DLG within fifteen (15) days following receipt of the completed audit or attestation engagement by the special purpose governmental entity.

(2)(a) A special purpose governmental entity required by KRS 65A.030(1)(a)(2) to contract for the provision of an attestation engagement shall ensure that it receives the attestation engagement no later than July 1, 2018, or, for an attestation engagement required by KRS 65A.030(1)(a)(2) after July 1, 2018, no more than four (4) years from the date of the special purpose governmental entity's last attestation engagement.

(b) A special purpose governmental entity required by KRS 65A.030(1)(b)(2) to contract for the provision of an independent audit shall ensure that it receives the independent audit no later than July 1, 2018, or, for an independent audit required by KRS 65A.030(1)(b)(2) after July 1, 2018, no more than four (4) years from the date of either:

1. The entity's last independent audit, or

2. The date the entity first reported to the DLG annual receipts from all sources or annual expenditures equal to or greater than \$100,000 but less than \$500,000.

(c) A special purpose governmental entity required by KRS 65A.030(1)(c)(2) to contract for the provision of an annual audit shall ensure that it receives an audit no more than one (1) year from the date it last reported to the DLG annual receipts from all sources or annual expenditures equal to or greater than \$500,000.

(3) Each submission shall be submitted to the DLG Web site as a portable document format (PDF) file.

(4) Except as provided in subsection (5) of this section, an audit shall be conducted on a modified cash basis of accounting as described in this subsection.

(a) Revenues shall be recognized when received.

(b) Expenditures shall be recognized when paid.

(c) Capital assets and long-term debt shall be reported when material to the special purpose governmental entity.

(d) Note disclosures shall include all those required by generally accepted accounting principles to the extent those disclosures apply to the special purpose governmental entity under the modified cash basis of accounting described in this subsection.

(e) Cash and other liquid assets available that are held in reserve for future purposes shall be disclosed.

(5) As an alternative to the minimum requirements established in subsection (3) of this section, an audit may be conducted under generally accepted accounting principles.

Section 6. Payment of the Registration Fee. (1) Each special purpose governmental entity shall pay the annual registration fee required by KRS 65A.020(5) within fifteen (15) days after the start of each fiscal period.

(a) The amount paid by each special purpose governmental entity shall be based on annual revenues of the special purpose governmental entity. For each fiscal period for which a registration fee is due, if the annual revenue information has not been submitted to the DLG as required by Section 4(3) of this administrative regulation, the annual revenues on which the registration fee shall be based shall be the annual revenues reported as part of the initial registration of the special purpose governmental entity pursuant to KRS 65A.090.

(b) Payment shall be made electronically, using the information reporting portal on the DLG Web site, at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm> unless permission to pay by an alternative method has been granted under subsections (2) and (3) of this section.

(c) Payment shall be accompanied by a completed DLG Form SPGE 101.

(2) A special purpose governmental entity may request permission to pay the registration fee by alternative means by submitting a written request that includes the following information at least thirty (30) days before the payment is due:

(a) The name of the special purpose governmental entity;

(b) A statement of the reason why the payment cannot be submitted using the standard electronic submission format; and

(c) The method of payment proposed.

(3)(a) Approval of an alternative method of payment shall be at the discretion of the DLG. If the DLG approves an alternative payment method, the special purpose governmental entity shall submit the payment in the form and format determined by the DLG and communicated to the special purpose governmental entity as part of the approval process.

(b) The DLG may withdraw approval to use an alternative payment method at any time by providing written notice of the withdrawal of approval to the special purpose governmental entity at least thirty (30) days prior to the effective date of the withdrawal of approval.

Section 7. Failure to File Required Information or to Pay the Annual Registration Fee in a Timely Manner. Any special purpose governmental entity that fails to file a report or form in the form and format and within the timeframes required by this administrative regulation, or that fails to submit payment of the annual registration fee as required by this administrative regulation, shall be subject to the provisions of KRS 65A.040.

Section 8. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) DLG Form SPGE 100, "Special Purpose Governmental Entity (SPGE) Registration and Board Reporting Form", September 2013; and

(b) DLG Form SPGE 101, "Special Purpose Governmental Entity (SPGE) Financial Disclosure Report", September 2013.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Local Government, 1024 Capital Center Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or online at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm>.

TONY WILDER, Commissioner

APPROVED BY AGENCY: December 6, 2013

FILED WITH LRC: December 18, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Tuesday, February 25, 2014 at 10:00 a.m. at the Department for Local Government, 1024 Capital Center Drive, 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 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 11:59 p.m. on February 28, 2014. 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: Darren T. Sammons, Staff Attorney, Department for Local Government, 1024 Capital Center Drive, Suite 341, Frankfort, Kentucky 40601, phone (502) 573-2382, fax (502) 573-2939.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Darren T. Sammons

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation prescribes and adopts the standard forms, protocols, timeframes, and due dates for the submission of information by special purpose governmental entities. This administrative regulation establishes the format for financial disclosure by special purpose governmental entities and prescribes the protocols, timeframes, and due dates for submission of information by special purpose governmental entities.

(b) The necessity of this administrative regulation: This administrative regulation is necessary for DLG to satisfy the requirements of KRS Chapter 65A.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms closely to the content of KRS Chapter 65A by establishing the manner in which special purpose governmental entities will register with DLG and submit the administrative and financial information required by statute. This administrative regulation imposes no additional requirements beyond those set forth by the statute or which DLG concludes are required by implication or otherwise are necessary for the statute to be effective.

(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 statute primarily by setting forth the mechanism by which special purpose governmental entities will report administrative and financial information and by prescribing the method by which such entities will pay the statutory fees.

(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: Not applicable.

(b) The necessity of the amendment to this administrative regulation: Not applicable.

(c) How the amendment conforms to the content of the authorizing statutes: Not applicable.

(d) How the amendment will assist in the effective administration of the statutes: Not applicable.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects entities that meet the definition of Special Purpose Governmental Entities as defined by KRS 65A.010. At present, DLG is aware of 1,272 entities that meet the statutory definition.

(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 regulated entities will have to file administrative and financial information with the Department for Local Government and will have to pay the statutory filing fee.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each entity will have to pay twenty-five (25) dollars, \$250 or \$500, as required by KRS 65A.020(5)(b).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The financial information for each special purpose governmental entity will be reported and published in an electronic format that will be accessible to all members of the public. Such greater transparency may increase public confidence in special purpose governmental entities.

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

(a) Initially: \$63,700, which has been provided as a Necessary Governmental Expense ("NGE").

(b) On a continuing basis: The statutory fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) years.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Funding has been provided as a Necessary Governmental Expense ("NGE") by the General Assembly.

(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 will be necessary to implement the administrative regulation. The fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) years.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation does not establish any fees, however, it does specify the method for payment of the fees that were established by KRS 65A.020(5)(b).

(9) TIERING: Is tiering applied? The fees were established by KRS 65A.020(5)(b), which applies tiering as follows: "Special Purpose Governmental Entities with an annual revenue from all sources of less than \$100,000, twenty-five (25) dollars;" "Special Purpose Governmental Entities with an annual revenue from all sources of at least \$100,000 but less than \$500,000, \$250;" and "Special Purpose Governmental Entities with an annual revenues of \$500,000 or greater, \$500."

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 Special Purpose Governmental Entities, as defined by KRS 65A.010(8), will be impacted by this regulation.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 65A.020, 65A.030, 65A.040, and 65A.090

(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 will have no effect on the expenditures and revenues of any state or local government agency. However, there may be an effect from the authorizing statute (KRS Chapter 65A).

(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 any state or local government agency. However, there may be revenue from the authorizing statute (KRS Chapter 65A), but any revenue is expected to cover the expense of the program itself.

(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 any state or local government agency. However, there may be revenue from the authorizing statute (KRS Chapter 65A), but any revenue is expected to cover the expense of the program itself.

(c) How much will it cost to administer this program for the first year? This program will cost an estimated \$63,700.

(d) How much will it cost to administer this program for subsequent years? The statutory fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) 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: No additional expenditures are necessary to implement this administrative regulation.

STATEMENT OF EMERGENCY **900 KAR 7:030E**

This emergency administrative regulation is being promulgated to incorporate by reference new data reporting manuals for use by hospitals and ambulatory facilities when submitting administrative claims data to the Cabinet for Health and Family Services, Office of Health Policy. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider –Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the 5 separate monthly actual discharge counts for outpatient services. An ordinary regulation is not sufficient because the changes are necessary so that accurate data may be collected beginning on January 1, 2014. Failure to enact this administrative regulation on an emergency basis will compromise the data necessary to provide data related to the cost, quality, and outcomes of health care services provided in the Commonwealth. This emergency administrative regulation shall be replaced by an ordinary administrative regulation 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 Health Policy** **(Emergency Amendment)**

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

RELATES TO: KRS Chapter 13B, 216.2920-216.2929
STATUTORY AUTHORITY: KRS 216.2923(3), 216.2925
EFFECTIVE: December 17, 2013

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216.2925 requires that the Cabinet for Health and Family Services promulgate administrative regulations requiring specified health care providers to provide the cabinet with data on cost, quality, and outcomes of health care services provided in the Commonwealth.

KRS 216.2923(3) authorizes the cabinet to promulgate administrative regulations to impose fines for failure to report required data. This administrative regulation establishes the required data elements, forms, and timetables for submission of data to the cabinet and fines for noncompliance.

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

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

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

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

(5) "Hospital" is defined by KRS 216.2920(6).

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

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

(b) Hospice care.

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

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

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

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

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

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

Section 3. Data Collection for Hospitals. (1) Inpatient Hospitalization records. Hospitals shall document every hospitalization they provide on a Standard Billing Form and shall, from every record, copy and provide to the cabinet the data specified in Section ~~12~~^{12[43]} of this administrative regulation.

(2) Outpatient services records.

(a) Hospitals shall document on a Standard Billing Form the outpatient services they provide and shall from every record, copy and provide to the cabinet the data specified in Section ~~12~~^{12[43]} of this administrative regulation.

(b) Hospitals shall submit records that contain the required

outpatient services procedure codes specified in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals.

(3) Data collection on patients. Hospitals shall submit required data on every patient as provided in Section 12[13] of this administrative regulation, regardless of the patient's billing or payment status.

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

(a) Ambulatory facilities shall document on a Standard Billing Form the outpatient services they provide and shall, for every record, copy and provide to the cabinet the data specified in Section 13[14] of this administrative regulation.

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

(2) Data collection on patients. Ambulatory facilities shall submit required data on every patient as provided in Section 13[14] of this administrative regulation, regardless of the patient's billing or payment status.

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

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

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

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

(2) Data submission responsibility.

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

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

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

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

(3) Transmission of records.

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

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

(c) All providers shall submit data by electronic transmission as specified by the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals and the Kentucky Data Coordinator's Manual for Ambulatory Facilities[records on computer-readable electronic media].

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

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

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

(b) The cabinet shall, within twenty-four (24) hours of

submission, verify by electronic message to each provider the receipt of the provider's data transmissions and the number of records in each transmission.

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

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

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

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

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

be the next working day.

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

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

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

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

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

(b) Providers shall submit to the cabinet corrected data by electronic transmission[~~or postmarked mailing~~] within thirty (30) days.

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

(3) Percentage error rate.

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

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

(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.[~~(d) For the first data submission, the cabinet shall not count as errors any data for patients admitted prior to thirty (30) days of the effective date of this administrative regulation.~~]

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

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

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

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

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

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

~~(3) Percentage error rate.~~

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

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

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

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

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

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

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

Section 9[40]. Extension or Waiver of Data Submission Timelines. (1) Providers experiencing extenuating circumstances or hardships may request from the cabinet, in writing, a data submission extension or waiver.

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

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

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

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

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

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

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

Section 10[44]. Appeals for Providers. (1) A provider notified of its noncompliance and assessed a fine pursuant to Section 8[9](1) of this administrative regulation shall have the right to appeal within thirty (30) days of the date of the notification letter.

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

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

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

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

Section 11[42]. Working Contacts for Providers. (1) On or before the last day of the data reporting period[By January 1 of each calendar year], a provider shall report by electronic transmission[letter] to the cabinet the names and telephone numbers of a designated contact person and one (1) back-up person to facilitate technical follow-up in data reporting and submission.

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

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

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

Section 12[43]. Required Data Elements for Hospitals. (1) Hospitals shall ensure that each record submitted to the cabinet contains at least the data elements identified in this section and as provided on the Standard Billing Form.

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

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

Required	DATA ELEMENT LABEL
Yes	*Provider Assigned Patient Control Number
Yes	*Provider Assigned Medical Record Number
Yes	*Type of Bill (inpatient, outpatient or other)
Yes	*Federal Tax Number or Employer Identification Number (EIN)
Yes	*Facility-specific NPI
Yes	*Statement Covers Period
Yes	*Patient City and Zip Code
Yes	*Patient Birth date
Yes	*Patient Sex
Yes	*Admission/Start of Care Date
Yes	Admission Hour
Yes	*Type of Admission
Yes	*Source of Admission
Yes	*Patient Status (at end of service or discharge)
No	Occurrence Codes & Dates
No	Value Codes and Amounts, including birth weight in grams
Yes	*Revenue Codes/Groups
Yes	*HCPCS/Rates/Hipps Rate Codes
No	Units of Service
Yes	*Total Charges by Revenue Code Category
Yes	*Payor Identification - Payor Name

Yes	*National Provider Identifier
Yes	*Diagnosis Version Qualifier - ICD version 9.0 or 10.0
Yes	*Principal Diagnosis Code
No	Principal Diagnosis Code present on admission identifier for non-Medicare claims
Yes	*Principal Diagnosis Code present on admission identifier for Medicare claims
Yes	*Secondary and Other Diagnosis Codes if present
No	Secondary and Other Diagnosis code present on admission identifier if present for non-Medicare claims
Yes	*Secondary and Other Diagnosis code present on admission identifier if present for Medicare claims
No	Inpatient Admitting Diagnosis or Outpatient reason for visit
Yes	*External Cause of Injury Code (E-code) if present
No	External Cause of Injury (E-code) present on admission identifier on non-Medicare claims if present
Yes	*External Cause of Injury (E-code) present on admission identifier on Medicare claims if present
Yes	*Principal Procedure Code & Date if present
Yes	*Secondary and Other Procedure Codes & Date if present
Yes	*Attending Physician NPI/QUAL/ID
No	Operating Clinician ID Number/NPI
No	Other Physician NPI/QUAL/ID
Yes	*Race
Yes	*Ethnicity
Yes	*Procedure Coding Method

Section 13[44]. Required Data Elements for Ambulatory Facilities.(1) Ambulatory facilities shall ensure that each record submitted to the cabinet contains at least the data elements identified in this section and as provided on the Standard Billing Form.

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

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

Required	DATA ELEMENT LABEL
Yes	*Patient Birth date
Yes	*Patient Sex
Yes	*Zip Code
Yes	*1st Individual Payer ID#
Yes	*Admission/Start of Care Date
Yes	*Type of Bill
Yes	*Principal Diagnosis Code
Yes	*Secondary and Other Diagnosis Codes if present
Yes	*Principal Procedure Code & Date
Yes	*Secondary and Other Procedure Codes & Date if present
Yes	*1st Units of Service
Yes	*1st Charge
No	Secondary and Other Units of Service and Charge
Yes	*Total Charges for the Case
Yes	*Attending Clinician NPI
Yes	*Provider Assigned Patient ID#
Yes	*1st Insurer Group #
No	2nd Insurer Group #
Yes	*Operating Clinician NPI
Yes	*Billing Facility-specific NPI
Yes	*Federal Tax Number or Employer Identification Number (EIN)
Yes	*Statement Covers Period
Yes	*Primary Payor Name

No	Secondary Payor Name
Yes	*Race
Yes	*Ethnicity
Yes	*HCPCS/Rates/Hipps Rate Codes

Section 14[15]. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals", revised January 1, 2014[2013]; and

(b) "Kentucky Data Coordinator's Manual for Ambulatory Facilities," revised January 1, 2014[2013].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, 275 East Main Street 4WE, Frankfort, Kentucky 40621[40601], Monday through Friday, 8 a.m. to 4:30 p.m.

EMILY WHELAN PARENTO, Executive Director

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 10, 2013

FILED WITH LRC: December 17, 2013 at 2 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone 502-564-7905, fax 502-564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Diona Mullins, (502) 564-9592

1. Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation provides clarification and instruction to specified health care providers on the process necessary to submit copies of administrative claims data to the Cabinet.

(b) The necessity of this administrative regulation: This administrative regulation is necessary so that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data. The administrative regulation contains the updated data submission manuals for hospitals and ambulatory care facilities. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider –Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary to ensure that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data to enable the Cabinet to publish the data and reports as required by KRS 216.2925.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed instructions to specified health care providers relating to the data elements, forms and timetables necessary to comply with 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 administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider –Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

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

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statute by providing a standardized method of reporting by hospitals and ambulatory care facilities.

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

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation will affect 229 hospitals and ambulatory facilities which submit data to the Cabinet.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will collect and submit data as required. Entities are already required to submit data. This administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider – Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Data integrity is improved as all applicable payor codes are now included in the manuals and instructions have been provided related to 1) the addition of the requirement to report new CPT/HCPCS codes, 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

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. The Office of Health Policy currently collects data and has the necessary data collection system in place.

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

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding for the implementation and enforcement of this administrative regulation will be the Office of Health Policy's existing budget. No new funding will be needed to implement the provisions of the amended 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 amendment may impact any government owned, controlled or proposed hospitals and ambulatory care facilities.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. The authorizing statutes are KRS 216.2920-216.2929.

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

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

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

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

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

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

Revenues (+/-): None

Expenditures (+/-): None

Other Explanation: None

STATEMENT OF EMERGENCY 900 KAR 10:100E

This emergency administrative regulation is being promulgated to establish the policies and procedures relating to appeals of eligibility determinations for KHBE participation and insurance affordability programs in accordance with 42 U.S.C. 18031 and 45 C.F.R. parts 155 and 156. This administrative regulation must be promulgated on an emergency basis: (a) 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. (b) 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 appeals by individuals of eligibility determinations for financial assistance issued by the Exchange. (c) Failure to enact this administrative regulation on an emergency basis will compromise the ability of the Exchange to timely respond to requests for appeals from individuals of eligibility determinations for financial assistance. 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
(New Emergency Administrative Regulation)

900 KAR 10:100E Appeals of Eligibility Determinations for KHBE Participation and Insurance Affordability Programs.

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: December 17, 2013

NECESSITY, FUNCTION, AND CONFORMITY: [EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) 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 for the provision of Medical Assistance to Kentucky's indigent citizenry. This administrative regulation establishes the coverage provisions and requirements relating to Medicaid Program home health care services for which payment shall be made by the Medicaid Program in behalf of both the categorically needy and the medically needy.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designee.

(2) "Electronic signature" is defined by KRS 369.102(8).

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Home health agency" or "HHA" means:

(a) An agency defined pursuant to 42 C.F.R. 440.70(d); and

(b) A Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.

(6) [(3)] "Home health aide" means a person who meets the home health aide requirements established in 902 KAR 20:081.

(7) [(4)] "Licensed practical nurse" or "LPN" means a person who is:

(a) Licensed in accordance with KRS 314.051; and

(b) Under the supervision of a registered nurse.

(8) "Managed care organization" 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.

(9) [(5)] "Medical social worker" means a person who meets the medical social worker requirements as established in 902 KAR 20:081.

(10) [(6)] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(11) [(7)] "Nursing service" means the delivery of medication, or treatment by a registered nurse or a licensed practical nurse supervised by a registered nurse, consistent with KRS Chapter 314 scope of practice provisions and the Kentucky Board of Nursing scope of practice determination guidelines.

(12) [(8)] "Occupational therapist" is defined by KRS 319A.010(3) [means a person who meets the occupational therapist requirements established in 902 KAR 20:081].

(13) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(14) [(9)] "Physical therapist" is defined by KRS 327.010(2) [means a person who meets the physical therapist requirements established in 902 KAR 20:081].

(15) "Physical therapy assistant" means a skilled health care worker who:

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

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

(16) [(10)] "Place of residence" means, excluding a hospital or nursing facility, the location at which a recipient resides.

(17) [(11)] "Plan of care" means a written plan which shall:

(a) Stipulate the type, nature, frequency and duration of a service; and

(b) Be reviewed and signed by a physician and HHA staff person at least every sixty (60) days.

(18) "Provider" is defined by KRS 205.8451(7).

(19) [(12)] "Qualified medical social worker" means a person who meets the qualified medical social worker requirements as established in 902 KAR 20:081.

(20) [(13)] "Qualified social work assistant" means a social work assistant as defined in 42 C.F.R. 484.4.

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

(22) [(14)] "Registered nurse" or "RN" is defined by KRS 314.011(5) [means a person licensed in accordance with KRS 314.041].

(23) [(15)] "Speech-language pathologist" is defined by KRS 334A.020(3) [means a person who meets the speech pathologist requirements established in 902 KAR 20:081].

(24) "Speech-language pathology assistant" is defined by KRS 334A.020(8).

Section 2. Conditions of Participation. (1) In order to provide home health services, a provider shall:

(a) Be an HHA; and

(b) Comply with:

1. 907 KAR 1:671;

2. [.] 907 KAR 1:672;

3. [.] and 907 KAR 1:673;

4. All applicable state and federal laws; and

5. [(c)] Comply with The Home Health Services Manual.

(2)(a) A home health provider shall maintain a medical record for each recipient for whom services are provided.

(b) A [The] medical record shall:

1. Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service [(a) Substantiate the services billed to the department and be signed and dated by HHA staff];

2. [(b)] Contain a copy of the plan of care;

3. [(c)] Document verbal orders from the physician, if applicable;

4. Except as established in paragraph (d) of this subsection, be retained for a minimum of five (5) years from the date a covered service is provided or until any audit dispute or issue is resolved beyond five (5) years;

5. [.] except in the case of a minor, whose records shall be retained for three (3) years after the recipient reaches the age of majority under state law, whichever is longest;

(e) Be kept in an organized central file within the HHA; and

6. [(f)] Be made available to the department upon request.

(c) The individual who provided a service shall date and sign the health record on the date that the individual provided the service.

(d) 1. If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (b)4. of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

2. In the case of a recipient who is a minor, the recipient's medical record shall be retained for three (3) years after the recipient reaches the age of majority under state law or the length established in paragraph (b)4 of this subsection or subparagraph 1 of this paragraph, whichever is longest.

(3) A provider shall comply with 45 C.F.R. Part 164.

(4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 3. Covered Services. (1) A home health service shall

be:

(a) ~~Effective November 15, 2001, be~~ Prior authorized by the department to ensure that the service or modification of the service is medically necessary and adequate for the needs of the recipient;

(b) ~~Be~~ Provided pursuant to a plan of care; and

(c) ~~Be~~ Provided in a recipient's place of residence.

(2) The following services provided to a recipient by a home health provider[,] who meets the requirements in Section 2 of this administrative regulation[,] shall be covered by the department:

(a) A nursing service which shall:

1. Include part-time or intermittent nursing services;

2. If provided daily, be limited to thirty (30) days unless additional days are prior authorized by the department;

(b) A therapy service which shall:

1. Include physical therapy services provided by a physical therapist or a qualified physical therapist assistant ~~[as defined in 42 C.F.R. 484.4]~~ who is under the supervision of a qualified physical therapist;

2. Include occupational therapy services provided by an occupational therapist or an a-qualified occupational therapy assistant ~~[as defined in 42 C.F.R. 484.4]~~ who is under the supervision of an a-qualified occupational therapist;

3. Include speech language pathology services ~~[therapy]~~ provided by ~~[or under the supervision of]~~ a speech-language pathologist or a speech-language pathology assistant who is under the supervision of a speech-language pathologist;

4. Be provided pursuant to a plan of treatment which shall be developed by the appropriate qualified therapist and physician; and

5. Be provided in accordance with 907 KAR 1:023; and

6. Comply with the:

a. Physical therapy service ~~[occupational therapy and speech therapy]~~ requirements established in the:

(i) ["Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is a physical therapy service provided to an adult; February 2000 Edition"] or

(ii) ["Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is a physical therapy service provided to a child; April 2000 Edition"];

b. Occupational therapy requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is an occupational therapy service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is an occupational therapy service provided to a child; or

c. Speech language pathology service requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the service is a speech language pathology service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the service is a speech language pathology service provided to a child;

(c) A home health aide service which shall:

1. Include the performance of simple procedures as an extension of therapy services, personal care, range of motion exercises and ambulation, assistance with medications that are ordinarily self-administered, reporting a change in the recipient's condition and needs, incidental household services which are essential to the recipient's health care at home when provided in the course of a regular visit, and completing appropriate records;

2. Be provided by a home health aide who is supervised at least every fourteen (14) days ~~[two (2) weeks]~~ by:

a. An RN;

b. A physical therapist, for any physical therapy services that are provided by the home health aide;

c. An occupational therapist, for any occupational therapy services that are provided by the home health aide; or

d. A speech-language pathologist ~~[therapist]~~, for any speech language pathology ~~[therapy]~~ services that are provided by the home health aide; and

3. Be a service that the recipient is either physically or mentally

unable to perform;

(d) A medical social service which shall:

1. Be provided by a qualified medical social worker or qualified social work assistant; and

2. Be provided in conjunction with at least one (1) other service listed in this section;

(e) A disposable medical supply which shall:

1. Include the following:

a. An adapter;

b. An applicator;

c. Drainage supplies;

d. Dressing supplies;

e. Catheter, ileostomy or ureostomy supplies;

f. Colostomy supplies;

g. A detection reagent for other than sugar or ketone;

h. Except for the limitations contained in Section 4(5) of this administrative regulation, diapers, underpads or incontinent pants;

i. An egg crate mattress;

j. An enema or elimination supplies including a fleet enema or dulcolax suppository;

k. Gastrostomy supplies;

l. Gloves;

m. Inhalation therapy supplies;

n. Irrigation solutions;

o. IV therapy supplies;

p. Lambs wool or a synthetic pad;

q. A lotion, powder or cream for an invalid or bedfast recipient;

r. A nipple if designed for cleft palate;

s. Inexpensive occupational therapy supplies which may include a plastic utensil holder or a long arm reacher;

t. Suction supplies;

u. Support supplies which may include antiembolism stockings, support vest, support gauntlet, or support glove;

v. A syringe or needle (excluding an insulin syringe for a diabetic);

w. Tracheostomy supplies; or

x. Tubing; and

2. If provided to a recipient who is not in need of a home health visit, be required to maintain him in his place of residence. A physician shall certify the medical necessity of a disposable medical supply by completing and signing a MAP 248 form; and

(f) An enteral nutritional product which shall:

1. Be ingested orally or delivered by tube into the gastrointestinal tract; and

2. Provide for the total or supplemental nutrition of a recipient.

Section 4. Limitations and Exclusions from Coverage. (1) A domestic or housekeeping service which is unrelated to the health care of a recipient shall not be covered.

(2) A medical social service shall not be covered unless provided in conjunction with another service pursuant to Section 3 of this administrative regulation.

(3) Supplies for personal hygiene shall not be covered.[]

(4) Drugs shall not be covered.

(5) Disposable diapers shall not be covered for a recipient age three (3) years and under, regardless of the recipient's medical condition.

(6) Except for the first week following a home delivery, a newborn or postpartum service without the presence of a medical complication shall not be covered.

(7) A recipient who has elected to receive hospice care shall not be eligible to receive coverage under the home health program.

(8)(a) There shall be an annual limit of twenty (20):

1. Occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection;

2. Physical therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection; and

3. Speech language pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limits established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined

to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for a speech language pathology service provided to the same recipient during the same time period via the home health services program.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 8. Auditing Authority. (1) The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights. (1) An appeal of an adverse[a negative] action taken by the department regarding a service and a recipient who is not enrolled with a managed care organization[Medicaid beneficiary] shall be in accordance with 907 KAR 1:563; or[.]

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:674].

Section 11.[6.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP-248, Commonwealth of Kentucky, Cabinet for Health Services, Department for Medicaid Services", December 2001[revision];

(b) "Home Health Services Manual", November 1993[edition];

(c) "Technical Criteria for Reviewing Ancillary Services for Adults", February 2000[Edition]; and

(d) "Technical Criteria for Reviewing Ancillary Services for Pediatrics", April 2000[Edition].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday 8 a.m. to 4:30 p.m.; or

(b) The Web site located at <http://www.chfs.ky.gov/dms/incorporated.htm>.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding home health services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding home health 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 Medicaid Program coverage provisions and requirements regarding home health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital 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 primary amendment establishes a uniform limit of twenty (20) occupational therapy service visits, physical therapy service visits, or speech pathology service visits per recipient per

calendar year. Additional services above the limit may be granted if additional services are determined to be medically necessary. This administrative regulation is being promulgated in conjunction with other administrative regulations - 907 KAR 8:010, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:020, Independent physical therapy service coverage provisions and requirements; 907 KAR 8:030, Independent speech pathology service coverage provisions and requirements; 907 KAR 10:014, Outpatient hospital services; and 907 KAR 3:005, Physician services – which will establish a uniform limit of twenty (20) therapy service visits per recipient per calendar year. Additional amendments include establishing that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to the same recipient by two (2) different providers at the same time; inserting records maintenance and relate confidentiality of medical records requirements; establishing that if third party liability exists for a given recipient that the provider is to bill the third party; establishing electronic signature requirements; and establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding.

(b) The necessity of the amendment to this administrative regulation: The Department for Medicaid Services (DMS) is establishing a limit of twenty (20) therapy service visits per recipient per calendar year across various programs in order to synchronize coverage with the "benchmark" or "benchmark equivalent plan" that DMS selected for a new eligibility group known as the "Medicaid expansion" group. States which grant eligibility to the expansion group are required (by the Affordable Care Act) to establish an alternative benefit plan (array of covered services including limits) for the group. The alternative benefit plan must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees;

The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year, DMS is adopting the same limit including for recipients of home health services. The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by comporting with federal requirements,

enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Outpatient hospitals will be affected by the amendment as will Medicaid recipients who receive physical therapy services, speech pathology services, or occupational therapy services via the home health program. Currently, there are ninety-nine (99) home health agencies participating in the Medicaid Program. 379 Medicaid recipients received speech pathology services via the home health program in the most recently completed state fiscal year. 1,742 Medicaid recipients received physical therapy services via the home health program in the most recently completed state fiscal year. 883 Medicaid recipients received occupational therapy services via the home health program in the most recently completed state fiscal year.

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

(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 or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Home health agencies will benefit by being reimbursed by the Medicaid Program for services provided in accordance with the requirements.

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

(a) Initially: DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state fiscal year DMS spent \$17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent \$5.9 million (state and federal funds combined.) Of the \$17.8 million spent by DMS on home health services, over \$104,000 (state and federal funds combined) was spent on occupational therapy services; over \$292,000 (state and federal funds combined) was spent on physical therapy services; and over \$41,000 was spent on speech pathology services. Of the \$5.9 million spent by MCOs in aggregate on home health services, over \$400,000 was spent on occupational therapy services; over \$678,000 was spent on physical therapy services; and over \$343,000 was spent on speech pathology services.

(b) On a continuing basis: Please see the response in (a).

(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 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: 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 the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.220.

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. Medicaid programs are required to cover "home health services (\$440.70) to any individual entitled to skilled nursing facility services."

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? Some home health agencies may be owned by local government entities, but DMS is unable to accurately predict the impact of this amendment as revenues will depend on utilization of services. Given that more individuals will be eligible for Medicaid services (not as a result of this administrative regulation though) utilization is expected to increase; thus, an increase in revenues is a logical expectation.

(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? Please see the response to question (a).

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment. DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state fiscal year DMS spent \$17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent \$5.9 million (state and federal funds combined.) Of the \$17.8 million spent by DMS on home health services, over \$104,000 (state and federal funds combined) was spent on occupational therapy services; over \$292,000 (state and federal funds combined) was spent on physical therapy services; and over \$41,000 was spent on speech pathology services. Of the \$5.9 million spent by MCOs in aggregate on home health services, over \$400,000 was spent on occupational therapy services; over \$678,000 was spent on physical therapy services; and over \$343,000 was spent on speech pathology services.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional 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:

STATEMENT OF EMERGENCY 907 KAR 1:019E

This emergency administrative regulation is being promulgated to eliminate the limit of four (4) prescription drugs per month; to establish program integrity provisions and safeguards in order to ensure appropriate utilization of services; and to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

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

907 KAR 1:019E. Outpatient Pharmacy Program.

RELATES TO: KRS Chapter 13B, 205.510, 205.560, 205.561, 205.5631-205.5639, 205.564, 205.6316, 205.8451, 205.8453, 217.015, 217.822, 42 C.F.R. 430.10, 431.54, 440.120, 447.331, 447.332, 447.333, 447.334, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396r-8

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.561, 205.5632, 205.5634, 205.5639(2), 205.564(10), (13); ~~2010 Extra. Sess. Ky. Acts ch. 1, Part I.G.3.b.(26)]~~

EFFECTIVE: December 30, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the 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 for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560 provides that the scope of medical care for which Medicaid shall pay is determined by administrative regulations promulgated by the cabinet. This administrative regulation establishes the provisions for coverage of drugs through the Medicaid Outpatient Pharmacy Program.

Section 1. Definitions. (1) "Brand name drug" means the registered trade name of a drug which was originally marketed under an original new drug application approved by the Food and Drug Administration.

(2) "Commissioner" is defined by KRS 205.5631(1).

(3) "Covered drug" means a drug for which the Department for Medicaid Services provides reimbursement if medically necessary and if provided, but not otherwise excluded, in accordance with Sections 2 and 3 of this administrative regulation.

(4) "Covered outpatient drug" is defined by 42 U.S.C. 1396r-8(k)(2).

(5) "Department" means the Department for Medicaid Services or its designated agent.

(6) "Department's pharmacy Internet Web site" or "Web site" means the Internet Web site maintained by the Department for Medicaid Services and accessible at <http://www.chfs.ky.gov/dms/Pharmacy.htm>.

(7) "Dosage form" means the type of physical formulation used to deliver a drug to the intended site of action, including a tablet, an

extended release tablet, a capsule, an elixir, a solution, a powder, a spray, a cream, an ointment, or any other distinct physical formulation recognized as a dosage form by the Food and Drug Administration.

(8) "Drug list" means the Department for Medicaid Services' list which:

(a) Specifies:

1. Drugs, drug categories, and related items not covered by the department; and

2. Covered drugs requiring prior authorization or having special prescribing or dispensing restrictions or excluded medical uses; and

(b) May include information about other drugs, drug categories, or related items and dispensing and prescribing information.

(9) "Drug Management Review Advisory Board" or "DMRAB" or "board" means the board established pursuant to KRS 205.5636.

(10) "Effective" or "effectiveness" means a finding that a pharmaceutical agent does or does not have a significant, clinically-meaningful therapeutic advantage in terms of safety, usefulness, or clinical outcome over the other pharmaceutical agents based on pertinent information from a variety of sources determined by the department to be relevant and reliable.

(11) "Emergency supply" means a seventy-two (72) hour supply.

(12) "Enrollee" means a recipient who is enrolled with a managed care organization.

(13) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(14)[(13)] "Food and Drug Administration" means the Food and Drug Administration of the United States Department of Health and Human Services.

(15)[(14)] "Generic drug" or "generic form of a brand name drug" means a drug which contains identical amounts of the same active drug ingredients in the same dosage form and which meets official compendia or other applicable standards of strength, quality, purity, and identity in comparison with the brand name drug.

(16)[(15)] "Legend drug" means a drug so defined by the Food and Drug Administration and required to bear the statement: "Caution: Federal law prohibits dispensing without prescription".

(17) "Managed care organization" 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.

(18)[(16)] "Manufacturer" is defined in 42 U.S.C. 1396r-8(k)(5).

(19)[(17)] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(20)[(18)] "Official compendia" or "compendia" is defined in 42 U.S.C. 1396r-8(g)(1)(B)(i).

(21)[(19)] "Over-the-counter drug" or "OTC drug" means a drug approved by the Food and Drug Administration to be sold without bearing the statement "Caution: Federal law prohibits dispensing without prescription".

(22)[(20)] "Pharmacy and Therapeutics Advisory Committee" or "committee" or "P&T Committee" means the pharmacy advisory committee established by KRS 205.564.

(23)[(21)] "Prescriber" means a health care professional who:

(a) within the scope of practice under Kentucky licensing laws, has the legal authority to write or order a prescription for the drug that is ordered;

(b) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672; and

(c) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671.

(24)[(22)] "Recipient" is defined by KRS 205.8451(9).

(25)[(23)] "Secretary" means the Secretary of the Cabinet for Health and Family Services.

(26)[(24)] "Supplemental rebate" means a cash rebate that offsets a Kentucky Medicaid expenditure and that supplements the Centers for Medicare and Medicaid Services National Rebate Program.

Section 2. Covered Benefits and Drug List. (1) A covered outpatient drug, nonoutpatient drug, or diabetic supply covered via this administrative regulation shall be:

(a) Medically necessary;

(b) Approved by the Food and Drug Administration; and

(c) Prescribed for an indication that has been approved by the Food and Drug Administration or for which there is documentation in official compendia or peer-reviewed medical literature supporting its medical use.

(2) A covered outpatient drug covered via this administrative regulation shall be prescribed on a tamper-resistant pad unless exempt pursuant to subsection (3) of this section.

(3) The tamper-resistant pad requirement established in subsection (2) of this section shall not apply to:

(a) An electronic prescription;

(b) A faxed prescription; or

(c) A prescription telephoned by a prescriber.

(4) To qualify as a tamper-resistant pad prescription, a prescription shall contain:

(a) One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and

(c) One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(5)(a) Except as provided in paragraph (b) of this subsection, the department shall cover the diabetic supplies listed in this paragraph via the department's pharmacy program and not via the department's durable medical equipment program established in 907 KAR 1:479:

1. A syringe with needle (sterile, 1cc or less);

2. Urine test or reagent strips or tablets;

3. Blood ketone test or reagent strip;

4. Blood glucose test or reagent strips for a home blood glucose monitor;

5. Normal, low, or high calibrator solution, chips;

6. Spring-powered device for lancet;

7. Lancets per box of 100; or

8. Home blood glucose monitor.

(b) The department shall cover the diabetic supplies listed in this paragraph via the department's durable medical equipment program established in 907 KAR 1:479 if:

1. The supply has an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100;

2. The supply has an a HCPCS code of A4206 and a diagnosis of diabetes is present on the corresponding claim; or

3. Medicare is the primary payor for the supply.

(6) The department shall have a drug list which:

(a) Lists:

1. Drugs, drug categories, and related items not covered by the department and, if applicable, excluded medical uses for covered drugs; and

2. Maintenance drugs covered by the department;

(b) Specifies those covered drugs requiring prior authorization or having special prescribing or dispensing restrictions;

(c) Specifies those covered drugs for which the maximum quantity limit on dispensing may be exceeded;

(d) Lists covered over-the-counter drugs;

(e) Specifies those legend drugs which are permissible restrictions under 42 U.S.C. 1396r-8(d), but for which the department makes reimbursement;

(f) May include a preferred drug list of selected drugs which have a more favorable cost to the department and which prescribers are encouraged to prescribe, if medically appropriate;

(g) May be updated monthly or more frequently by the department; and

(h) Shall be posted on the department's Internet pharmacy Web site.

(6)(a) The department may implement drug treatment protocols requiring the use of medically-appropriate drugs which are available without prior authorization before the use of drugs which

require prior authorization.

(b) The department may approve a request from the prescriber or a pharmacist for exemption of a specific recipient from the requirement established in paragraph (a) of this subsection, based on documentation that drugs available without prior authorization:

(a) Were used and were not an effective medical treatment or lost their effectiveness;

(b) Are reasonably expected to not be an effective medical treatment;

(c) Resulted in, or are reasonably expected to result in, a clinically-significant adverse reaction or drug interaction; or

(d) Are medically contraindicated.

Section 3. Exclusions and Limitations. (1) The following drugs shall be excluded from coverage:

(a) A drug which the Food and Drug Administration considers to be:

1. A less-than-effective drug; or

2. Identical, related, or similar to a less-than-effective drug;

(b) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:

1. A drug if used for anorexia, weight loss, or weight gain;

2. A drug if used to promote fertility;

3. A drug if used for cosmetic purposes or hair growth;

4. A drug if used for the symptomatic relief of cough and colds;

5. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;

6. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;

7. A barbiturate;

8. A benzodiazepine;

9. A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or

10. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;

(c) A drug for which the manufacturer has not entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a), unless there has been a review and determination by the department that it is in the best interest of a recipient for the department to make payment for the drug and federal financial participation is available for the drug;

(d) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service;

(e) A drug for which the department requires prior authorization if prior authorization has not been approved; and

(f) A drug that has reached the manufacturer's termination date, indicating that the drug may no longer be dispensed by a pharmacy.

(2) If authorized by the prescriber, a prescription for a:

(a) Controlled substance in Schedule III-V may be refilled up to five (5) times within a six (6) month period from the date the prescription was written or ordered, at which time a new prescription shall be required; or

(b) Noncontrolled substance, except as prohibited in subsection (4) of this section, may be refilled up to eleven (11) times within a twelve (12) month period from the date the prescription was written or ordered, at which time a new prescription shall be required.

(3) For each initial filling or refill of a prescription, a pharmacist shall dispense the drug in the quantity prescribed not to exceed a thirty-two (32) day supply unless:

(a) The drug is designated in the department's drug list as a drug exempt from the thirty-two (32) day dispensing limit in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;

(b) A prior authorization request has been submitted on the Drug Prior Authorization Request Form (MAP-82001) and

approved by the department because the recipient needs additional medication while traveling or for a valid medical reason, in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;

(c) The drug is prepackaged by the manufacturer and is intended to be dispensed as an intact unit and it is impractical for the pharmacist to dispense only a month's supply because one (1) or more units of the prepackaged drug will provide more than a thirty-two (32) day supply; or

(d) The prescription fill is for an outpatient service recipient, excluding an individual who is receiving supports for community living services in accordance with 907 KAR 1:145.

(4) A prescription fill for a maintenance drug for an outpatient service recipient who has demonstrated stability on the given maintenance drug, excluding an individual receiving supports for community living services in accordance with 907 KAR 1:145 or 907 KAR 12:010, shall be dispensed in a ninety-two (92) day supply unless:

(a) The department determines that it is in the best interest of the recipient to dispense a smaller supply; or

(b) The recipient is covered under the Medicare Part D benefit in which case the department shall not cover the prescription fill.

(5) The department may require prior authorization for a compounded drug that requires preparation by mixing two (2) or more individual drugs; however, the department may exempt a compounded drug or compounded drug category from prior authorization if there has been a review and determination by the department that it is in the best interest of a recipient for the department to make payment for the compounded drug or compounded drug category.

(6) A prescriber shall make his or her national provider identifier (NPI) available to a pharmacist, and the prescriber's NPI shall be recorded on each pharmacy claim.

~~(7) [(a) Except as provided in paragraph (b), (c), or (d) of this subsection, the department shall cover no more than a total of four (4) prescriptions, of which no more than three (3) shall be brand name prescriptions per recipient per month.~~

~~(b) The four (4) prescription limit shall not apply if the recipient:~~

~~1. Is under nineteen (19) years of age;~~

~~2. Uses insulin for the management of diabetes; or~~

~~3. Is a nursing facility resident who does not have Medicare Part D drug coverage.~~

~~(c) A pharmacist may utilize a four (4) prescription limit override code for a recipient whose prescription will exceed the four (4) prescription limit if the prescription is prescribed:~~

~~1. For any of the following conditions:~~

~~a. Acute infection or infestation;~~

~~b. Bipolar disorder;~~

~~c. Cancer;~~

~~d. Cardiac rhythm disorder;~~

~~e. Chronic pain;~~

~~f. Coronary artery or cerebrovascular disease (advanced atherosclerotic disease);~~

~~g. Cystic fibrosis;~~

~~h. Dementia;~~

~~i. Diabetes;~~

~~j. End stage lung disease;~~

~~k. End stage renal disease;~~

~~l. Epilepsy;~~

~~m. Hemophilia;~~

~~n. HIV or AIDS or immunocompromised;~~

~~o. Hyperlipidemia;~~

~~p. Hypertension;~~

~~q. Major depression;~~

~~r. Metabolic syndrome;~~

~~s. Organ transplant; or~~

~~t. Psychotic disorder; or~~

~~2. As part of:~~

~~a. Acute therapy for migraine headache or acute pain; or~~

~~b. Suppressive therapy for thyroid cancer.~~

~~(d) An additional prescription or prescriptions shall be covered if the department determines that it is in the best interest of the~~

~~recipient to cover an additional prescription or prescriptions whether brand name or generic.~~

~~(8) The department shall cover up to three (3) brand name prescriptions per member per month unless the department determines that it is in the best interest of the member to cover any additional brand name prescriptions.~~

(9) A refill of a prescription shall not be covered unless at least ninety (90) percent of the prescription, except for a refill for a recipient who is a resident of a personal care home or a resident of a facility reimbursed pursuant to 907 KAR 1:025 or 1:065, time period has elapsed.

(b) A refill of a prescription for a recipient who is a resident of a facility or entity referenced in paragraph (a) of this subsection shall not be covered unless at least eighty (80) percent of the prescription time has lapsed.

Section 4. Prior Authorization Process. (1)(a) To request prior authorization for a drug:

1. The applicable form as required by this section shall be completed and submitted to the department:

a. By fax, mail, express delivery service, or messenger service; or

b. Via the department's pharmacy Internet Web site; or

2. A requester may provide the information required on the applicable form to the department verbally via the telephone number published on the department's pharmacy Internet Web site.

(b) If drug therapy needs to be started on an urgent basis to avoid jeopardizing the health of a recipient or to avoid causing substantial pain and suffering, the completed request form may be sent to the department's urgent fax number or submitted to the department via the department's pharmacy Internet Web site.

(2) A Drug Prior Authorization Request Form shall be used by a:

(a) Prescriber or pharmacist to request prior authorization for a drug except for a brand name drug, Suboxone®, Subutex®, Zyvox®, Synagis®, or an atypical antipsychotic agent;

(b) Pharmacist to request an early refill of a prescription; or

(c) Pharmacist to obtain prior authorization for special dispensing requests involving exceptions to the thirty-two (32) day maximum quantity limit including additional drugs needed for travel or other valid medical reasons.

(3)(a) Except as established in paragraph (c) of this subsection, a Brand Name Drug Request Form shall be used by a prescriber to request prior authorization for a brand name drug if a generic form of the drug is available.

(b) Regarding a Brand Name Drug Request Form, a prescriber shall:

1. Complete the form;

2. Include on the form:

a. The handwritten phrase "brand medically necessary" or "brand necessary"; and

b. The provider's signature for each specific drug requested; and

3. Indicate:

a. Whether the recipient has received treatment with available generic forms of the brand name drug and the length of therapy; and

b. Why the recipient's medical condition is unable to be adequately treated with the generic forms of the drug.

(c) Submission of a Brand Name Drug Request Form shall not be required if:

1. The department has specifically exempted the drug, via the drug list, from this requirement;

2. It has been determined by the department to be in the best interest of a recipient not to require submission of a Brand Name Drug Request Form; or

3. The prescriber certifies that the brand name drug is medically necessary in accordance with subsection (3)(b) of this section.

(d) In addition to the requirements established in paragraphs (a) through (c) of this subsection, the prescriber shall certify a

brand name only request by including for each brand name drug requested, the prescriber's signature and the phrase "Brand Medically Necessary" or "Brand Necessary" handwritten directly on:

1. The prescription;

2. The nursing facility order sheet; or

3. A separate sheet of paper that:

a. Includes the name of the recipient and the brand name drug requested; and

b. Is attached to the original prescription or nursing facility order sheet.

(4) A Mental Health Drug Authorization Request Form for Atypical Antipsychotic Agents shall be:

(a) Used to request prior authorization for an atypical antipsychotic drug; and

(b) Completed and submitted as directed on the form.

(5) A Suboxone® and Subutex® Prior Authorization Request Form shall be:

(a) Used to request prior authorization for Suboxone® or Subutex®; and

(b) Completed and submitted as directed on the form.

(6) A Zyvox® (linezolid) Drug Authorization Request Form shall be:

(a) Used to request prior authorization for Zyvox®; and

(b) Completed and submitted as directed on the form.

(7) A Synagis® Prior Authorization Request Form shall be:

(a) Used to request prior authorization for Synagis®; and

(b) Completed and submitted as directed on the form.

(8) If a recipient presents a prescription to a pharmacist for a drug which requires prior authorization, the pharmacist:

(a) Shall, unless the form is one[+] which has to be completed by the prescriber, submit a request for prior authorization in accordance with this section;

(b) Shall notify the prescriber or the prescriber's authorized representative that the drug requires prior authorization and:

1. If the prescriber indicates that a drug list alternative available without prior authorization is acceptable and provides a new prescription, shall dispense the drug list alternative; or

2. If the prescriber indicates that drug list alternatives available without prior authorization have been tried and failed or are clinically inappropriate or if the prescriber is unwilling to consider drug list alternatives, shall:

a. Request that the prescriber obtain prior authorization from the department; or

b. Unless the form is one[+] which has to be completed by the prescriber, submit a prior authorization request in accordance with this section; or

(c) Except as restricted by subparagraphs 3 and 4 of this paragraph, may provide the recipient with an emergency supply of the prescribed drug in an emergency situation in accordance with this subsection.

1. The emergency situation shall:

a. Occur outside normal business hours of the department's drug prior authorization office, except for medications dispensed to a long term care recipient in which an emergency supply may be dispensed after 5 p.m. EST; and

b. Exist if, based on the clinical judgment of the dispensing pharmacist, it would reasonably be expected that, by a delay in providing the drug to the recipient, the health of the recipient would be placed in serious jeopardy or the recipient would experience substantial pain and suffering.

2. At the time of the dispensing of the emergency supply, the pharmacist shall in accordance with this section:

a. Submit a prior authorization request to the department's urgent fax number or to the department via the department's pharmacy Internet Web site; or

b. If applicable, notify the prescriber as soon as possible that an emergency supply was dispensed and that the prescriber is required to obtain prior authorization for the requested drug from the department.

3. An emergency supply shall not be provided for an over-the-counter (OTC) drug.

4. An emergency supply shall not be provided for a drug excluded from coverage in accordance with Section 3(1) (a), (b) or (c) of this administrative regulation.

5. The quantity of the emergency supply shall be:

a. The lesser of a seventy-two (72) hour supply of the drug or the amount prescribed; or

b. The amount prescribed if it is not feasible for the pharmacist to dispense just a seventy-two (72) hour supply because the drug is packaged in such a way that it is not intended to be further divided at the time of dispensing but rather dispensed as originally packaged.

(9)(a) If a prescriber submits a prescription to a pharmacy via telephone, the prescriber shall also fax the prescription for a controlled substance to the pharmacy within forty-eight (48) hours of submitting it via telephone.

(b) A pharmacy shall not be denied payment for services for the failure of the prescriber to fax the prescription for a controlled substance to the pharmacy if the pharmacy:

1. Requests a faxed prescription from the prescriber;

2. Documents the request for a faxed prescription; and

3. Documents that a faxed prescription, which was not received, was not received.

(10) The department's notification of a decision on a request for prior authorization shall be made in accordance with the following:

(a) If the department approves a prior authorization request, notification of the approval shall be provided by telephone, fax or via the department's pharmacy Internet Web site to the party requesting the prior authorization and, if known, to the pharmacist.

(b) If the department denies a prior authorization request:

1. The department shall provide a denial notice:

a. By mail to the recipient and in accordance with 907 KAR 1:563; and

b. By fax, telephone, or if necessary by mail to the party who requested the prior authorization.

(11)(a) The department may grant approval of a prior authorization request for a drug for a specific recipient for a period of time not to exceed 365 days.

(b) Approval of a new prior authorization request shall be required for continuation of therapy subsequent to the expiration of a time-limited prior authorization request.

(12) Prior authorization of drugs for a Medicaid long-term care recipient in a nursing facility shall be in accordance with this subsection.

(a) The department may specify in its drug list specific drugs or drug classes which shall:

1. Not be exempted from prior authorization; or

2. Be exempt from prior authorization for Medicaid recipients in nursing facilities.

(b) A brand name drug for which the department requires completion by the prescriber of a Brand Name Drug Request Form in accordance with this section shall not be exempted from prior authorization.

Section 5. Placement of Drugs on Prior Authorization. (1) Except as excluded by Section 3(1)(a) to (c) of this administrative regulation, upon initial coverage by the Kentucky Medicaid Program, a drug that is newly approved for marketing by the Food and Drug Administration under a product licensing application, new drug application, or a supplement to a new drug application and that is a new chemical or molecular entity shall be subject to prior authorization in accordance with KRS 205.5632.

(2) Upon request by the department, a drug manufacturer shall provide the department with the drug package insert information.

(3) The drug review process to determine if a drug shall require prior authorization shall be in accordance with this subsection and KRS 205.5632.

(a) The determination as to whether a drug is in an excludable category specified in Section 3(1) of this administrative regulation shall be made by the department.

1. If a drug, which has been determined to require prior authorization becomes available on the market in a new strength, package size, or other form that does not meet the definition of a

new drug the new strength, package size, or other form shall require prior authorization.

2. A brand name drug for which there is a generic form that contains identical amounts of the same active drug ingredients in the same dosage form and that meets compendial or other applicable standards of strength, quality, purity, and identity in comparison with the brand name drug shall require prior authorization in accordance with Section 4 of this administrative regulation, unless there has been a review and determination by the department that it is in the best interest of a recipient for the department to cover the drug without prior authorization.

(b) The committee shall make a recommendation to the department regarding prior authorization of a drug based on:

1. A review of clinically-significant adverse side effects, drug interactions and contraindications and an assessment of the likelihood of significant abuse of the drug; and

2. An assessment of the cost of the drug compared to other drugs used for the same therapeutic indication and whether the drug offers a substantial clinically-meaningful advantage in terms of safety, effectiveness, or clinical outcome over other available drugs used for the same therapeutic indication. Cost shall be based on the net cost of the drug after federal rebate and supplemental rebates have been subtracted from the cost.

(c)1. Within thirty (30) days of the date the committee's recommendation is posted on the department's pharmacy Internet Web site, the secretary, in consultation with the commissioner and the department's pharmacy staff, shall review the recommendations of the committee and make the final determination whether a drug requires prior authorization.

2. If the recommendation of the committee is not accepted, the secretary shall inform the committee of the basis for the final determination in accordance with Section 8(3) of this administrative regulation.

(4) The department may exclude from coverage or require prior authorization for a drug which is a permissible restriction in accordance with 42 U.S.C. 1396r-8(d).

Section 6. Drug Management Review Advisory Board Meeting Procedures and Appeals. (1) A person may address the DMRAB if:

(a) The presentation is directly related to an agenda item; and

(b) The person gives notice to the department (and gives a copy to the DMRAB chairperson) by fax or email at least five (5) business days prior to the meeting.

(2) A verbal presentation:

(a) In aggregate per drug per drug manufacturer shall not exceed three (3) minutes with two (2) additional minutes allowed for questions from the DMRAB, if required; or

(b) By an individual on a subject shall not exceed three (3) minutes with two (2) additional minutes allowed for questions from the DMRAB, if required.

(3) The proposed agenda shall be posted on the department's pharmacy Internet Web site at least fourteen (14) days prior to the meeting.

(4) An appeal of a final decision by the commissioner by a manufacturer of a product shall be in accordance with KRS 205.5639(5). The appeal request shall:

(a) Be in writing;

(b) State the specific reasons the manufacturer believes the final decision to be incorrect;

(c) Provide any supporting documentation; and

(d) Be received by the department within thirty (30) days of the manufacturer's actual notice of the final decision.

Section 7. Pharmacy and Therapeutics Advisory Committee Meeting Procedures. (1) A P&T Committee meeting agenda shall be posted as required by KRS 205.564(6).

(2) A P&T committee meeting shall be conducted in accordance with KRS 205.564.

(3) A public presentation at a P&T Committee meeting shall comply with this subsection.

(a)1. A verbal presentation in aggregate per drug per drug manufacturer shall not exceed three (3) minutes with two (2) additional minutes allowed for questions from the P&T Committee,

if required.

2. A verbal presentation by an individual on a subject shall not exceed five (5) minutes.

3. A request to make a verbal presentation shall be submitted in writing via fax or e-mail to the department with a copy to the chair of the P&T Committee no later than five (5) business days in advance of the P&T Committee meeting.

4. An individual may only present new information (package insert changes, new indication or peer-reviewed journal articles) on a product or information on a new product.

5. A presentation shall be limited to an agenda item.

(b) Nonverbal comments, documents, or electronic media material (limited to package insert changes, new indication, or peer reviewed journal articles) shall be:

1.a. E-mailed to the department in a Microsoft compatible format (for example, Word, Power Point, Excel or other standard file formats including Adobe Acrobat's pdf format); or

b. Mailed to the department with a total of twenty-five (25) copies mailed so that the department may distribute copies to P&T Committee members as well as to any other involved parties; and

2. Received by the department no later than seven (7) days prior to the P&T Committee meeting.

(4) The department may prepare written recommendations or options for drug review for the committee and shall post them as required by KRS 205.564(6).

(5) A recommendation by the committee shall require a majority vote.

(6) Recommendations of the committee shall be posted as required by KRS 205.564(8).

(7) A drug manufacturer may request that its name be placed on the department's distribution list for agendas of committee meetings. Placement of a drug manufacturer's name on the distribution list shall be valid through December 31 of each year, at which time the drug manufacturer shall be required to again request placement on the distribution list. To request placement of the drug manufacturer's name on the distribution list, the drug manufacturer shall submit the request in writing to the department and shall provide the following information about the drug manufacturer:

- (a) Manufacturer's name;
- (b) Mailing address;
- (c) Telephone number;
- (d) Fax number;
- (e) E-mail address; and
- (f) Name of a contact person.

Section 8. Review and Final Determination by the Secretary.

(1) An interested party who is adversely affected by a recommendation of the committee may submit a written exception to the secretary in accordance with the following:

(a) The written exception shall be received by the secretary within seven (7) calendar days of the date of the committee meeting at which the recommendation was made; and

(b) Only information that was not available to be presented at the time of the committee's meeting shall be included in the written exception.

(2) After the time for filing written exceptions has expired, the secretary shall consider the recommendation of the committee and all exceptions that were filed in a timely manner prior to making a final determination. The secretary shall issue a final determination, and a dated public notice of the final determination shall be posted on the department's pharmacy Internet Web site for six (6) months. A copy of the final determination may be requested from the department after it is issued.

(3) The secretary shall make a final determination in accordance with KRS 205.564(9).

(4) A final determination by the secretary may be appealed in accordance with KRS Chapter 13B. A decision of the secretary to remand the recommendation to the committee shall not constitute a final decision for purposes of an appeal pursuant to KRS Chapter 13B. An appeal request shall:

- (a) Be in writing;
- (b) Be sent by mail, messenger, carrier service, or express-

delivery service to the secretary in a manner that safeguards the information;

(c) State the specific reasons the final determination of the secretary is alleged to be erroneous or not based on the facts and law available to the committee and the secretary at the time of the decision;

(d) Be received by the secretary within thirty (30) days of the date of the posting of the final determination on the department's pharmacy Internet Web site; and

(e) Be forwarded by the secretary to the Administrative Hearings Branch of the Cabinet for Health and Family Services for processing in accordance with the provisions of KRS Chapter 13B.

Section 9. Confirming Receipt of Prescription. (1) A recipient, or a designee of the recipient, shall sign their name in a format which allows their signature to be reproduced or preserved at a pharmacy confirming that the recipient received the prescription.

(2) A pharmacist shall maintain, or be able to produce a copy of, a log of recipient signatures referenced in subsection (1) of this section for at least six (6) years.

Section 10. Exemptions to Prescriber Requirements. The department shall reimburse for:

(1) A full prescription prescribed by a provider who is not enrolled in the Kentucky Medicaid Program, if the department determines that reimbursing for a full prescription is in the best interest of the recipient; or

(2) An emergency supply of a prescription prescribed by a provider who is not enrolled in the Kentucky Medicaid Program, if the department determines that reimbursing for the emergency supply is in the best interest of the recipient.

Section 11. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient receives a dispensing of a drug prescription from a pharmacist enrolled with the Medicaid Program, the department shall not reimburse for the same drug prescription dispensing provided to the same recipient during the same time period from another pharmacist.

Section 12. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 13. 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 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, or 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 14. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 15. Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.~~[A provision 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 provision; or~~
- ~~(2) Disapproves the provision].~~

Section 16.~~[12.]~~ Appeal Rights. (1) An appeal of an adverse action taken by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be~~[A Medicaid recipient may appeal the department's denial, suspension, reduction, or termination of a covered drug or decision regarding the amount of a drug dispensed based upon an application of this administrative regulation]~~ in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

Section 17.~~[13.]~~ Incorporation by Reference. (1) The following material is incorporated by reference:

- (a) "Drug Prior Authorization Request Form", May 15, 2007 edition;
- (b) "Brand Name Drug Request Form", May 15, 2007 edition;
- (c) "Mental Health Drug Authorization Request Form for Atypical Antipsychotic Agents", May 15, 2007 edition;
- (d) "Subaxone® and Subutex® Prior Authorization Request Form", September 22, 2009 edition;
- (e) "Zyvox® (linezolid) Drug Authorization Request Form", January 11, 2010 edition; and
- (f) "Synagis® Prior Authorization Request Form", November 2010 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: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(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 provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation currently assists and will continue to assist in the effective administration of the authorizing statutes by establishing the provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(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 eliminates the four (4) prescriptions per recipient per month limit; inserts various program integrity requirements such as that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to a recipient at the same time by two (2) different providers; establishes third party liability requirements (Medicaid is the payor of last resort); establishes general provider participation requirements (program integrity requirements); establishes the option of using electronic signatures along with corresponding requirements; and establishes that DMS's coverage of drugs under this administrative regulation is contingent upon federal approval and federal funding.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to synchronize the Department for Medicaid Services' coverage of outpatient drugs with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan imposed no prescription drug limit, DMS is removing the four (4) prescription per recipient per month limit. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing DMS's coverage of prescription drugs is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided.

(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 comporting with the Affordable Care Act, enhancing program integrity of Medicaid benefits, and protecting taxpayer revenues.

(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 comporting with the Affordable Care Act, enhancing program integrity of Medicaid benefits, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid-reimbursed prescribing providers are affected by this amendment and recipients are affected as well.

(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: Providers will need to continue to ensure that they bill appropriately.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Medicaid recipients will benefit by no longer being limited to four (4) prescriptions per month; however, the limit was not a hard limit.

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

(a) Initially: DMS anticipates little if any increased costs as a result of lifting the four (4) prescription per month limit as the limit was "soft" (could be over-ridden if medically necessary.)

(b) On a continuing basis: DMS anticipates little if any increased costs as a result of lifting the four (4) prescription per month limit as the limit was "soft" (could be over-ridden if medically necessary.)

(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 to implement this amendment.

(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 was not appropriate in this administrative regulation as the administrative regulation applies equally to all those individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b).

2. State compliance standards. KRS 205.560 establishes "The scope of medical care for which the Cabinet for Health and Family Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section."

3. Minimum or uniform standards contained in the federal mandate. This amendment is necessary to synchronize the Department for Medicaid Services' coverage of outpatient drugs with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-

7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan imposed no prescription drug limit, DMS is removing the four (4) prescription per recipient per month limit. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.)

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. It does not impose stricter standards or 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 is affected by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 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 amendment will not generate any additional revenue for state or local governments during the first year of implementation.

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

(c) How much will it cost to administer this program for the first year? No additional costs are necessary to implement this amendment during the first DMS anticipates little if any increased costs as a result of lifting the four (4) prescription per month limit as the limit was "soft" (could be over-ridden if medically necessary.)

(d) How much will it cost to administer this program for subsequent years? No additional costs are necessary to implement this amendment during subsequent years. DMS anticipates little if any increased costs as a result of lifting the four (4) prescription per month limit as the limit was "soft" (could be over-ridden if medically necessary.)

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

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

**STATEMENT OF EMERGENCY
907 KAR 1:030E**

This emergency administrative regulation is being promulgated to adopt a uniform limit for physical therapy services, occupational therapy services, and speech pathology services for Medicaid recipients in contrast to the current varied limits based on the individual's benefit plan; to establish program integrity provisions and safeguards in order to ensure appropriate utilization of services; and to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

**CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Community Alternatives
(Emergency Amendment)**

907 KAR 1:030E. Home health agency services.

RELATES TO: KRS 205.520, 42 C.F.R. 440.70, 447.325, 484.4, 45 C.F.R. 164.316, 42 U.S.C. 1396a-d
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), EO-2004-726]

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: [EO-2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) 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 [for the provision of Medical Assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the coverage provisions and requirements relating to Medicaid Program home health care services [for which payment shall be made by the Medicaid Program in behalf of both the categorically needy and the medically needy].

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designee.

(2) "Electronic signature" is defined by KRS 369.102(8).

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Home health agency" or "HHA" means:

(a) An agency defined pursuant to 42 C.F.R. 440.70(d); and

(b) A Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.

(6) [(3)] "Home health aide" means a person who meets the home health aide requirements established in 902 KAR 20:081.

(7) [(4)] "Licensed practical nurse" or "LPN" means a person who is:

(a) Licensed in accordance with KRS 314.051; and

(b) Under the supervision of a registered nurse.

(8) "Managed care organization" 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.

(9) [(5)] "Medical social worker" means a person who meets the medical social worker requirements as established in 902 KAR

20:081.

(10) [(6)] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(11) [(7)] "Nursing service" means the delivery of medication, or treatment by a registered nurse or a licensed practical nurse supervised by a registered nurse, consistent with KRS Chapter 314 scope of practice provisions and the Kentucky Board of Nursing scope of practice determination guidelines.

(12) [(9)] "Occupational therapist" is defined by KRS 319A.010(3) [means a person who meets the occupational therapist requirements established in 902 KAR 20:081].

(13) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(14) [(9)] "Physical therapist" is defined by KRS 327.010(2) [means a person who meets the physical therapist requirements established in 902 KAR 20:081].

(15) "Physical therapy assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and
(b) Performs physical therapy services and related duties as assigned by the supervising physical therapist.

(16) [(40)] "Place of residence" means, excluding a hospital or nursing facility, the location at which a recipient resides.

(17) [(41)] "Plan of care" means a written plan which shall:

(a) Stipulate the type, nature, frequency and duration of a service; and

(b) Be reviewed and signed by a physician and HHA staff person at least every sixty (60) days.

(18) "Provider" is defined by KRS 205.8451(7).

(19) [(42)] "Qualified medical social worker" means a person who meets the qualified medical social worker requirements as established in 902 KAR 20:081.

(20) [(43)] "Qualified social work assistant" means a social work assistant as defined in 42 C.F.R. 484.4.

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

(22) [(14)] "Registered nurse" or "RN" is defined by KRS 314.011(5) [means a person licensed in accordance with KRS 314.041].

(23) [(45)] "Speech-language pathologist" is defined by KRS 334A.020(3) [means a person who meets the speech pathologist requirements established in 902 KAR 20:081].

(24) "Speech-language pathology assistant" is defined by KRS 334A.020(8).

Section 2. Conditions of Participation. (1) In order to provide home health services, a provider shall:

(a) Be an HHA; and

(b) Comply with:

1. 907 KAR 1:671;

2. [.] 907 KAR 1:672;

3. [.] and] 907 KAR 1:673;

4. All applicable state and federal laws; and

5. [(c) Comply with] The Home Health Services Manual.

(2) (a) A home health provider shall maintain a medical record for each recipient for whom services are provided.

(b) A [The] medical record shall:

1. Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service [(a) Substantiate the services billed to the department and be signed and dated by HHA staff];

2. [(b)] Contain a copy of the plan of care;

3. [(c)] Document verbal orders from the physician, if applicable;

4. Except as established in paragraph (d) of this subsection, be retained for a minimum of five (5) years from the date a covered service is provided or until any audit dispute or issue is resolved beyond five (5) years;

5. [.] except in the case of a minor, whose records shall be retained for three (3) years after the recipient reaches the age of majority under state law, whichever is longest;

(e) Be kept in an organized central file within the HHA; and

6. [(f)] Be made available to the department upon request.

(c) The individual who provided a service shall date and sign the health record on the date that the individual provided the service.

(d)1. If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (b)4. of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

2. In the case of a recipient who is a minor, the recipient's medical record shall be retained for three (3) years after the recipient reaches the age of majority under state law or the length established in paragraph (b)4 of this subsection or subparagraph 1 of this paragraph, whichever is longest.

(3) A provider shall comply with 45 C.F.R. Part 164.

(4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 3. Covered Services. (1) A home health service shall be:

(a)[Effective November 15, 2001, be] Prior authorized by the department to ensure that the service or modification of the service is medically necessary and adequate for the needs of the recipient;

(b)[Be] Provided pursuant to a plan of care; and

(c)[Be] Provided in a recipient's place of residence.

(2) The following services provided to a recipient by a home health provider[,] who meets the requirements in Section 2 of this administrative regulation[,] shall be covered by the department:

(a) A nursing service which shall:

1. Include part-time or intermittent nursing services;

2. If provided daily, be limited to thirty (30) days unless additional days are prior authorized by the department;

(b) A therapy service which shall:

1. Include physical therapy services provided by a physical therapist or a[qualified] physical therapy[therapist] assistant [as defined in 42 C.F.R. 484.4] who is under the supervision of a[qualified] physical therapist;

2. Include occupational therapy services provided by an occupational therapist or an[a-qualified] occupational therapy assistant [as defined in 42 C.F.R. 484.4] who is under the supervision of an[a-qualified] occupational therapist;

3. Include speech language pathology services[therapy] provided by [or under the supervision of] a speech-language pathologist or a speech-language pathology assistant who is under the supervision of a speech-language pathologist;

4. Be provided pursuant to a plan of treatment which shall be developed by the appropriate[qualified] therapist and physician; and

5. Be provided in accordance with 907 KAR 1:023; and

6. Comply with the:

a. Physical therapy service[, occupational therapy and speech therapy] requirements established in the:

(i) ["]Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is a physical therapy service provided to an adult[, February 2000 Edition"] or

(ii) ["]Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is a physical therapy service provided to a child[, April 2000 Edition"];

b. Occupational therapy requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is an occupational therapy service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is an occupational therapy service provided to a child; or

c. Speech language pathology service requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults

if the service is a speech language pathology service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the service is a speech language pathology service provided to a child;

(c) A home health aide service which shall:

1. Include the performance of simple procedures as an extension of therapy services, personal care, range of motion exercises and ambulation, assistance with medications that are ordinarily self-administered, reporting a change in the recipient's condition and needs, incidental household services which are essential to the recipient's health care at home when provided in the course of a regular visit, and completing appropriate records;

2. Be provided by a home health aide who is supervised at least every fourteen (14) days[two (2) weeks] by:

a. An RN;

b. A physical therapist, for any physical therapy services that are provided by the home health aide;

c. An occupational therapist, for any occupational therapy services that are provided by the home health aide; or

d. A speech-language pathologist[therapist], for any speech language pathology[therapy] services that are provided by the home health aide; and

3. Be a service that the recipient is either physically or mentally unable to perform;

(d) A medical social service which shall:

1. Be provided by a qualified medical social worker or qualified social work assistant; and

2. Be provided in conjunction with at least one (1) other service listed in this section;

(e) A disposable medical supply which shall:

1. Include the following:

a. An adapter;

b. An applicator;

c. Drainage supplies;

d. Dressing supplies;

e. Catheter, ileostomy or ureostomy supplies;

f. Colostomy supplies;

g. A detection reagent for other than sugar or ketone;

h. Except for the limitations contained in Section 4(5) of this administrative regulation, diapers, underpads or incontinent pants;

i. An egg crate mattress;

j. An enema or elimination supplies including a fleet enema or dulcolax suppository;

k. Gastrostomy supplies;

l. Gloves;

m. Inhalation therapy supplies;

n. Irrigation solutions;

o. IV therapy supplies;

p. Lambs wool or a synthetic pad;

q. A lotion, powder or cream for an invalid or bedfast recipient;

r. A nipple if designed for cleft palate;

s. Inexpensive occupational therapy supplies which may include a plastic utensil holder or a long arm reacher;

t. Suction supplies;

u. Support supplies which may include antiembolism stockings, support vest, support gauntlet, or support glove;

v. A syringe or needle (excluding an insulin syringe for a diabetic);

w. Tracheostomy supplies; or

x. Tubing; and

2. If provided to a recipient who is not in need of a home health visit, be required to maintain him in his place of residence. A physician shall certify the medical necessity of a disposable medical supply by completing and signing a MAP 248 form; and

(f) An enteral nutritional product which shall:

1. Be ingested orally or delivered by tube into the gastrointestinal tract; and

2. Provide for the total or supplemental nutrition of a recipient.

Section 4. Limitations and Exclusions from Coverage. (1) A domestic or housekeeping service which is unrelated to the health care of a recipient shall not be covered.

(2) A medical social service shall not be covered unless provided in conjunction with another service pursuant to Section 3 of this administrative regulation.

(3) Supplies for personal hygiene shall not be covered.[:]

(4) Drugs shall not be covered.

(5) Disposable diapers shall not be covered for a recipient age three (3) years and under, regardless of the recipient's medical condition.

(6) Except for the first week following a home delivery, a newborn or postpartum service without the presence of a medical complication shall not be covered.

(7) A recipient who has elected to receive hospice care shall not be eligible to receive coverage under the home health program.

(8)(a) There shall be an annual limit of twenty (20):

1. Occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection;

2. Physical therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection; and

3. Speech language pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limits established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for a speech language pathology service provided to the same recipient during the same time period via the home health services program.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 8. Auditing Authority. (1) The department shall have

the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights. (1) An appeal of an adverse[a negative] action taken by the department regarding a service and a recipient who is not enrolled with a managed care organization[Medicaid beneficiary] shall be in accordance with 907 KAR 1:563; or[:]

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671].

Section 11.[6.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP-248, Commonwealth of Kentucky, Cabinet for Health Services, Department for Medicaid Services", December 2001[revision];

(b) "Home Health Services Manual", November 1993[edition];

(c) "Technical Criteria for Reviewing Ancillary Services for Adults", February 2000[Edition]; and

(d) "Technical Criteria for Reviewing Ancillary Services for Pediatrics", April 2000[Edition].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday 8 a.m. to 4:30 p.m.; or

(b) The Web site located at <http://www.chfs.ky.gov/dms/incorporated.htm>.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding home health services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding home health 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 Medicaid Program coverage provisions and requirements regarding home health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital 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 primary amendment establishes a uniform limit of twenty (20) occupational therapy service visits, physical therapy service visits, or speech pathology service visits per recipient per calendar year. Additional services above the limit may be granted if additional services are determined to be medically necessary. This administrative regulation is being promulgated in conjunction with other administrative regulations - 907 KAR 8:010, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:020, Independent physical therapy service coverage provisions and requirements; 907 KAR 8:030, Independent speech pathology service coverage provisions and requirements; 907 KAR 10:014, Outpatient hospital services; and 907 KAR 3:005, Physician services – which will establish a uniform limit of twenty (20) therapy service visits per recipient per calendar year. Additional amendments include establishing that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to the same recipient by two (2) different providers at the same time; inserting records maintenance and relate confidentiality of medical records requirements; establishing that if third party liability exists for a given recipient that the provider is to bill the third party; establishing electronic signature requirements; and establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding.

(b) The necessity of the amendment to this administrative regulation: The Department for Medicaid Services (DMS) is establishing a limit of twenty (20) therapy service visits per recipient per calendar year across various programs in order to synchronize coverage with the "benchmark" or "benchmark equivalent plan" that DMS selected for a new eligibility group known as the "Medicaid expansion" group. States which grant eligibility to the expansion group are required (by the Affordable Care Act) to establish an alternative benefit plan (array of covered services including limits) for the group. The alternative benefit plan must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year, DMS is adopting the same limit including for recipients of home health services. The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with federal requirements,

enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Outpatient hospitals will be affected by the amendment as will Medicaid recipients who receive physical therapy services, speech pathology services, or occupational therapy services via the home health program. Currently, there are ninety-nine (99) home health agencies participating in the Medicaid Program. 379 Medicaid recipients received speech pathology services via the home health program in the most recently completed state fiscal year. 1,742 Medicaid recipients received physical therapy services via the home health program in the most recently completed state fiscal year. 883 Medicaid recipients received occupational therapy services via the home health program in the most recently completed state fiscal year.

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

(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 or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Home health agencies will benefit by being reimbursed by the Medicaid Program for services provided in accordance with the requirements.

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

(a) Initially: DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state fiscal year DMS spent \$17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent \$5.9 million (state and federal funds combined.) Of the \$17.8 million spent by DMS on home health services, over \$104,000 (state and federal funds combined) was spent on occupational therapy services; over \$292,000 (state and federal funds combined) was spent on physical therapy services; and over \$41,000 was spent on speech pathology services. Of the \$5.9 million spent by MCOs in aggregate on home health services, over \$400,000 was spent on occupational therapy services; over \$678,000 was spent on physical therapy services; and over \$343,000 was spent on speech pathology services.

(b) On a continuing basis: Please see the response in (a).

(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 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: 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 the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.220.

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. Medicaid programs are required to cover "home health services (\$440.70) to any individual entitled to skilled nursing facility services."

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? Some home health agencies may be owned by local government entities, but DMS is unable to accurately predict the impact of this amendment as revenues will depend on utilization of services. Given that more individuals will be eligible for Medicaid services (not as a result of this administrative regulation though) utilization is expected to increase; thus, an increase in revenues is a logical expectation.

(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? Please see the response to question (a).

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment. DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state fiscal year DMS spent \$17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent \$5.9 million (state and federal funds combined.) Of the \$17.8 million spent by DMS on home health services, over \$104,000 (state and federal funds combined) was spent on occupational therapy services; over \$292,000 (state and federal funds combined) was spent on physical therapy services; and over \$41,000 was spent on speech pathology services. Of the \$5.9 million spent by MCOs in aggregate on home health services, over \$400,000 was spent on occupational therapy services; over \$678,000 was spent on physical therapy services; and over \$343,000 was spent on speech pathology services.

(d) How much will it cost to administer this program for

subsequent years? DMS anticipates no additional 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:

STATEMENT OF EMERGENCY

907 KAR 1:038E

This emergency administrative regulation is being promulgated in conjunction with three (3) other emergency administrative regulations – 907 KAR 1:039E, Hearing program reimbursement provisions and requirements; 907 KAR 1:631E, Vision program reimbursement provisions and requirements; and 907 KAR 1:632E, Vision program coverage provisions and requirements to eliminate annual dollar limits on a benefit (eyeglasses); to establish program integrity provisions to ensure appropriate utilization of services; and to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding. Currently, the administrative regulation contains annual dollar caps of \$200 and \$400 on eyeglasses. These limits must be eliminated to comply with an Affordable Care Act mandate. The Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits." Medicaid benefits are within the scope of essential health benefits. Vision service provisions are being removed from this administrative regulation altogether and simultaneously established in a new and separate administrative regulation (907 KAR 1:632E, Vision program coverage provisions and requirements), but this administrative regulation had to be promulgated in concert with the new vision administrative regulation as this administrative regulation contained vision program provisions including the federally prohibited annual dollar limit. This action must be taken on an emergency basis to comply with an Affordable Care Act mandate and to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Provider Operations

(Emergency Amendment)

907 KAR 1:038E. Hearing Program coverage provisions and requirements[Hearing and Vision Program services].

RELATES TO: KRS 205.520, 334.010(4), (9), 334A.020(5), 334A.030, 42 C.F.R. 441.30, 447.53, 457.310, 42 U.S.C. 1396a, b, d, 1396r-6

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

EFFECTIVE: December 26, 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program provisions and requirements regarding the coverage of audiology services and hearing instruments[hearing services and vision services for which payment shall be made by the Medicaid

Program].

Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

(2) ~~"Comprehensive choices" means a benefit plan for an individual who:~~

~~(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. A nursing facility in accordance with 907 KAR 1:022;~~

~~2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090; 3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or~~

~~4. The Model Waiver II Program in accordance with 907 KAR 1:595; and~~

~~(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.~~

(3) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(3)[(4)] "Department" means the Department for Medicaid Services or its designee.

(4) "Enrollee" means a recipient who is enrolled with a managed care organization.

(5) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(6) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or time.

~~(7)[(5)] "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.~~

(6) "Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to:

1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;

2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

6. 42 C.F.R. 457.310; and

(b) Has a designated package code of 2, 3, 4, or 5.

(7) "Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive K-TAP benefits and are deprived due to death, incapacity, or absence;

2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or

3. Do not receive K-TAP benefits and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. Receive SSP benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(h) Pregnant women; or

(i) Medicaid works individuals.

(8) "Hearing instrument" is defined by KRS 334.010(4).

(8) "Managed care organization" 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.

(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(10) "Recipient" is defined by KRS 205.8451(9).["Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53]

(11) "Optimum choices" means a benefit plan for an individual who:

~~(a) Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. An intermediate care facility for individuals with an intellectual disability in accordance with 907 KAR 1:022; or~~

~~2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and~~

~~(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.~~

(12) "Specialist in hearing instruments" is defined by KRS 334.010(9).

Section 2. General Requirements. (1)(a) For the department to reimburse for a service or item, the service or item shall:

1. Be provided:

a. To a recipient under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21); and

b. By a provider who is:

(i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Authorized to provide the service in accordance with this administrative regulation;

2. Be covered in accordance with this administrative regulation;

3. Be medically necessary;

4. Have a CPT code or HCPCS code that is listed on the Department for Medicaid Services Hearing Program Fee Schedule.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(3) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(5)(a) An in-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license in accordance with KRS Chapter 334A;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department; and

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department.

(b) An out-of-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license to practice audiology in the state in which the audiologist is licensed;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association if the audiologist is out of state.

(c) If an audiologist fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the audiologist is in-state or out-of-state, the:

1. Audiologist shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the audiologist effective with the date the audiologist fails or failed to comply.

(6)(a) An out-of-state hearing instrument dispenser shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the licensing board with jurisdiction over hearing instrument dispensers in the state in which the license is held;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association.

(c) If a specialist in hearing instruments fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the specialist in hearing instruments is in-state or out-of-state, the:

1. Specialist in hearing instruments shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the specialist in hearing instruments effective with the date the specialist in hearing instruments fails or failed to comply.

Section 3. Audiology Services. (1) Audiology service[Hearing Services. (1) All hearing] coverage shall be limited to:

(a) A service provided:

1. To a recipient[Limited to an individual] under the age of

twenty-one (21) years, including the month in which the individual becomes twenty-one (21); and

2. By an audiologist who:

a. Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

b. Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

c.(i) Meets the in-state audiologist requirements established in Section 2(5)(a) of this administrative regulation if the audiologist is an in-state audiologist; or

(ii) Meets the out-of-state audiologist requirements established in Section 2(5)(b) of this administrative regulation if the audiologist is an out-of-state audiologist;

(b) A medically necessary service;

(c) One (1) complete hearing evaluation per calendar year; and

(d) A CPT code or HCPCS code listed on the Department for Medicaid Services Hearing Program Fee Schedule[; and

(b) Provided in accordance with the Hearing Program Manual].

(2) Unless a recipient's health care provider demonstrates, and the department agrees, that an additional hearing instrument evaluation is medically necessary, a[services in excess of the limitations established in this subsection are medically necessary, reimbursement for services provided by an audiologist licensed pursuant to KRS 334A.030 to a recipient shall be limited to:

(a) The following procedures which shall be covered only if a recipient is referred by a physician to an audiologist licensed pursuant to KRS 334A.030:

Code	Procedure
92552	Pure Tone audiometry (threshold); air only
92555	Speech audiometry threshold
92556	Speech audiometry threshold; with speech recognition
92557	Comprehensive audiometry evaluation
92567	Tympanometry
92568	Acoustic reflex testing
92579	Visual reinforcement audiometry
92585	Auditory evoked potentials
92587	Evoked otoacoustic emissions
92588	Complete or diagnostic evaluation (comparison of transient or distortion product otoacoustic emissions at multiple levels and frequency)
92541	Spontaneous nystagmus test
92542	Positional nystagmus test
92543	Caloric vestibular test
92544	Optokinetic nystagmus test
92545	Oscillating tracking test
92546	Sinusoidal-vertical axis rotational testing
92547	Use of vertical electrodes

(b) Complete hearing evaluation;

(e)[hearing instrument evaluation shall:

(a) Be limited to being provided to an individual under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21);

(b) Include three (3) follow-up visits which shall be:

1. Within the six (6)-month period immediately following the fitting of a hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument; and

(c) Include one (1) additional follow-up visit which shall be[;

(d) Three (3) follow-up visits that shall be:

1. Within the six (6)-month period immediately following fitting of a hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument; and

(e) One (1) additional follow-up visit that is[;

1. At least six (6) months following the fitting of the hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument.

(3)(a) A referral by a physician to an audiologist shall be required for an audiology service.

(b) The department shall not cover an audiologist service if no

referral from a physician to the audiologist was made.

Section 4. Hearing Instrument Coverage. [(3)] Hearing instrument benefit coverage shall:

(1) Be limited to a benefit:

(a) For an individual under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21);

(b) Provided by a specialist in hearing instruments or audiologist who meets the:

1. In-state specialist in hearing instruments requirements established in Section 2(6) of this administrative regulation if the specialist in hearing instruments is an in-state specialist in hearing instruments; or

2. Out-of-state audiologist requirements established in Section 2(6) of this administrative regulation if the audiologist is an out-of-state audiologist;

(c) That is medically necessary; and

(d) That has a corresponding HCPCS code listed on the Department for Medicaid Services Hearing Program Fee Schedule;

(2) If the benefit is a hearing instrument model, [(a)] be for a hearing instrument model that is:

(a)[1-] Recommended by an audiologist licensed pursuant to KRS 334A.030; and

(b)[2-] Available through a Medicaid-participating specialist in hearing instruments; and

(3)[(b)] Not exceed \$800 per ear every thirty-six (36) months; and

(e) Be limited to the following procedures:

Code	Procedure
V5010	Assessment for Hearing instrument
V5011	Fitting, Orientation, Checking of Hearing instrument
V5014	Repair, Modification of Hearing Instrument
V5015	Hearing Instrument Repair Professional Fee
V5020	Conformity Evaluation
V5030	Hearing Instrument, Monaural, Body Aid Conduction
V5040	Hearing Instrument, Monaural, Body Worn, Bone Conduction
V5050	Hearing Instrument, Monaural, In the Ear Hearing
V5060	Hearing Instrument, Monaural, Behind the Ear Hearing
V5070	Glasses; Air Conduction
V5080	Glasses; Bone Conduction
V5090	Dispensing Fee, Unspecified Hearing Instrument
V5095	Semi-Implantable Middle Ear Hearing Prosthesis
V5100	Hearing Instrument, Bilateral, Body Worn
V5120	Binaural; Body
V5130	Binaural; In the Ear
V5140	Binaural; Behind the Ear
V5150	Binaural; Glasses
V5160	Dispensing Fee, Binaural
V5170	Hearing Instrument, Cros, In the Ear
V5180	Hearing Instrument, Cros, Behind the Ear
V5190	Hearing Instrument, Cros, Glasses
V5200	Dispensing Fee, Cros
V5210	Hearing Instrument, Bicos, In the Ear
V5220	Hearing Instrument, Bicos, Behind the Ear
V5230	Hearing Instrument, Bicos, Glasses
V5240	Dispensing Fee, Bicos
V5241	Dispensing Fee, Monaural Hearing Instrument, Any Type
V5242	Hearing Instrument, Analog, Monaural, CIC (Completely In the Ear Canal)
V5243	Hearing Instrument, Analog, Monaural, ITC (In the Canal)
V5244	Hearing Instrument, Digitally Programmable Analog, Monaural, CIC
V5245	Hearing Instrument, Digitally Programmable Analog, Monaural, ITC
V5246	Hearing Instrument, Digitally Programmable Analog, Monaural, ITE (In the Ear)

V5247	Hearing Instrument, Digitally Programmable Analog, Monaural, BTE (Behind the Ear)
V5248	Hearing Instrument, Analog, Binaural, CIC
V5249	Hearing Instrument, Analog, Binaural, ITC
V5250	Hearing Instrument, Digitally Programmable Analog, Binaural, CIC
V5251	Hearing Instrument, Digitally Programmable Analog, Binaural, ITC
V5252	Hearing Instrument, Digitally Programmable, Binaural, ITE
V5253	Hearing Instrument, Digitally Programmable, Binaural, BTE
V5254	Hearing Instrument, Digital, Monaural, CIC
V5255	Hearing Instrument, Digital, Monaural, ITC
V5256	Hearing Instrument, Digital, Monaural, ITE
V5257	Hearing Instrument, Digital, Monaural, BTE
V5258	Hearing Instrument, Digital, Binaural, CIC
V5259	Hearing Instrument, Digital, Binaural, ITC
V5260	Hearing Instrument, Digital, Binaural, ITE
V5261	Hearing Instrument, Digital, Binaural, BTE
V5262	Hearing Instrument, Disposable, Any Type, Monaural
V5263	Hearing Instrument, Disposable, Any Type, Binaural
V5264	Ear Mold (One (1) Ear Mold Per Year Per Ear and if Medically Necessary)]
V5266	Hearing Instrument Battery (Limit of Four (4) Per Instrument When Billed With A New Hearing Instrument Or A Replacement Instrument)
V5267	Hearing Instrument Supplies, Accessories
V5299	Hearing Service Miscellaneous (May Be Used to Bill Warranty Replacement Hearing Instruments But Shall be Covered Only if Prior Authorized by the Department)]

Section 5. Replacement of a Hearing Instrument. (1) The department shall reimburse for the replacement of a hearing instrument if:

(a) A loss of the hearing instrument necessitates replacement;

(b) Extensive damage has occurred necessitating replacement;

or

(c) A medical condition necessitates the replacement of the previously prescribed instrument or equipment in order to accommodate a change in hearing loss.

(2) If replacement of a hearing instrument is necessary within twelve (12) months of the original fitting, the replacement hearing instrument shall be fitted upon the signed and dated recommendation from an audiologist.

(3) If replacement of a hearing instrument becomes necessary beyond twelve (12) months from the original fitting:

(a) The recipient shall be examined by a physician with a referral to an audiologist; and

(b) The recipient's hearing loss shall be re-evaluated by an audiologist.

Section 6. Noncovered services. The department shall not reimburse for:

(1) A routine screening of an individual or group of individuals for identification of a hearing problem;

(2) Hearing therapy except as covered through the six (6)-month adjustment counseling following the fitting of a hearing instrument;

(3) Lip reading instructions except as covered through the six (6)-month adjustment counseling following the fitting of a hearing instrument;

(4) A service for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment;

(5) A telephone call;

(6) A service associated with investigational research; or

(7) A replacement of a hearing instrument for the purpose of incorporating a recent improvement or innovation unless the

replacement results in appreciable improvement in the recipient's hearing ability as determined by an audiologist.

Section 7. Equipment. (1) Equipment used in the performance of a test shall meet the current standards and specifications established by the American National Standards Institute.

(2)(a) A provider shall ensure that any audiometer used by the provider or provider's staff shall:

1. Be checked at least once per year to ensure proper functioning; and

2. Function properly.

(b) A provider shall:

1. Maintain proof of calibration and any repair, if any repair occurs; and

2. Make the proof of calibration and repair, if any repair occurs, available for departmental review upon the department's request.

Section 8. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 9.[3. Vision Program Services. (1) Vision program coverage shall be limited to:

(a) A prescription service;

(b) A repair service made to a frame;

(c) A diagnostic service provided by:

1. An ophthalmologist; or

2. An optometrist to the extent the optometrist is licensed to perform the service.

(2) Eyeglass coverage shall:

(a) Be limited to a recipient who is under age twenty-one (21); and

(b) Not exceed:

1. \$200 per year for a recipient in the global choices benefit package; or

2. \$400 per year for a recipient in the comprehensive choices, family choices, or optimum choices benefit package.

(3) To be covered:

(a) A service designated as a physical medicine and rehabilitation service CPT code shall require prior authorization if provided to a recipient age twenty-one (21) or over;

(b) A radiology service specified in 907 KAR 3:005, Section 5, shall require prior authorization regardless of a recipient's age;

(c) A service shall be provided in accordance with the Vision Program Manual; and

(d) A lens shall be polycarbonate and scratch-coated.

Section 4.-] Appeal Rights.[(4)] An appeal of a negative action regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563. [(2) An appeal of a negative action regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.]

Section 10.[5.-] Incorporation by Reference. (1) The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013,[following material] is incorporated by reference[:

(a) "The Vision Program Manual", October 2007 edition, Department for Medicaid Services; and

(b) "The Hearing Program Manual", October 2007 edition, Department for Medicaid Services].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m.

to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(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 Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(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 Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

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

(a) How the amendment will change this existing administrative regulation: This amendment eliminates the definitions of and references to four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices; removes vision program provisions as they are being addressed in a separate administrative regulation; clarifies the age limit for audiology services; incorporates by reference a fee schedule which establishes the services with corresponding Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes covered by DMS; un-incorporates the Hearing Program Manual and inserts provisions from the manual into this administrative regulation; inserts program integrity requirements; inserts a section to address hearing instrument coverage; inserts a section addressing hearing instrument replacement; and establishes that the coverage provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding. Included in the existing vision provisions (all of which are being removed and inserted into a new administrative regulation - 907 KAR 1:632) are the \$200 and \$400 annual limits on eyewear. Those limits (along with all other vision provisions) are being deleted from this administrative regulation; however, those limits will not be included in the new vision services administrative regulation as annual dollar limits on benefits violates an Affordable Care Act mandate. This amended administrative regulation is being promulgated in concert with three (3) other related administrative regulations– 907 KAR 1:039, Hearing program reimbursement provisions and requirements; 907 KAR 1:631, Vision program reimbursement provisions and requirements; and 907 KAR 1:632, Vision program coverage provisions and requirements.

(b) The necessity of the amendment to this administrative regulation: Eliminating the references to the four (4) benefit plans is necessary as DMS is eliminating the four (4) benefit plans [via a companion repealer administrative regulation which will repeal the administrative regulation (907 KAR 1:900, KyHealth Choices) which created the four (4) plans.] Eliminating provisions regarding vision service coverage is necessary as those provisions are being established in a new, separate administrative regulation;

eliminating the manual previously incorporated by reference is necessary as provisions previously contained in the manual are being inserted into the body of this administrative regulation; and inserting program integrity requirements is necessary to enhance program integrity. Adopting a fee schedule is necessary to provide information in a reader friendly format for providers (via the fee schedule incorporated by reference.) Additionally, the \$200 and \$400 annual limits on eye glasses must be removed as a result of a federal mandate. The Affordable Care Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits." Medicaid benefits are within the scope of essential health benefits. Again, vision service provisions are being simultaneously established in a new and separate administrative regulation (907 KAR 1:632), but this amended administrative regulation had to be promulgated in concert with the new vision administrative regulation as this administrative regulation contained vision program provisions including the federally prohibited annual dollar limit. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by eliminating provisions regarding vision service coverage as they are being addressed in a separate administrative regulation; by inserting provisions from a manual previously incorporated by reference into the body of this administrative regulation; by enhancing program integrity; by providing information in a reader friendly format for providers; and by eliminating references to four (4) benefit plans which DMS is eliminating.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by eliminating provisions regarding vision service coverage as they are being addressed in a separate administrative regulation; by inserting provisions from a manual previously incorporated by reference into the body of this administrative regulation; by enhancing program integrity; by providing information in a reader friendly format for providers; and by eliminating references to four (4) benefit plans which DMS is eliminating.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: For calendar year 2012, eleven (11) specialists in hearing instruments billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and sixty-nine (69) audiologists billed the Medicaid program. 3,510 individuals (managed care and fee-for-service combined) received services from specialists in hearing instruments in calendar year 2012 and 3,236 individuals (managed care and fee-for-service combined) received services from audiologists during the same period.

(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 by the amendment other than to properly bill for services and adhere to program integrity requirements.

(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 by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients will benefit due to the elimination of an annual dollar limit on eyeglasses. Medicaid providers may benefit from having a reader friendly fee schedule to view and from clarifications.

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(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 matching state funds appropriated in the biennium budget.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied as hearing services are limited to individuals under twenty-one (21) years of age as this is a component of mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services pursuant to 42 U.S.C. 1396d(r)(4) and 42 C.F.R. 441.56.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396d(r)(4), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 441.56, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. KRS 194A.050(1) states, "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 205.520(3) states: "... 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. EPDST hearing coverage must include at least testing and diagnosis and treatment for hearing defects, including hearing aids. Hearing services must also be, "provided—

(i) At intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition." Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to

safeguard against unnecessary utilization of such care and services..." 45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

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. The requirements are not 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 (DMS) will be affected by this amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 441.56. and 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 will generate no revenue for DMS.

(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 will generate no revenue for DMS.

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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

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

STATEMENT OF EMERGENCY 907 KAR 1:039E

This emergency administrative regulation is being promulgated in conjunction with 907 KAR 1:038E, Hearing program coverage provisions and requirements, to establish program integrity provisions and safeguards in order to ensure appropriate utilization of services as well as to protect the health, safety, and welfare of Medicaid recipients. Additionally, the amended administrative regulation being promulgated to establish that Medicaid Program

coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (Emergency Amendment)

907 KAR 1:039E. Hearing Program reimbursement provisions and requirements[Payments for hearing services].

RELATES TO: KRS 205.520, 334.010, 334.040, 334.200, 334A.020(5), 42 C.F.R. 447.200, 204

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

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program[of Medical Assistance]. 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the reimbursement provisions and requirements for covered audiology services, hearing instruments, and related items provided to a Medicaid recipient who is not enrolled with a managed care organization[method for determining amounts payable by the department for hearing services].

Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

(2) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology["Comparable instrument" means an instrument falling within the general classifications of fitting type, for example, body, behind the ear, in the ear, or eyeglasses].

(3) "Department" means the Department for Medicaid Services.

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

(5) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or time.

(6) "Hearing instrument" is defined by KRS 334.010(4).

(7) "Managed care organization" 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.

(8) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Participating audiologist" means an audiologist who:

(a) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(b) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(c) Meets the audiologist requirements established in 907 KAR 1:038.

(10) "Participating specialist in hearing instruments" means a specialist in hearing instruments who:

(a) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(b) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(c) Meets the specialist in hearing instruments requirements established in 907 KAR 1:038.

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

(12){(6)} "Specialist in hearing instruments" is defined by KRS 334.010(9).

(13) "Usual and customary charge" means the uniform amount that a provider bills to the general public for a specific covered benefit.

Section 2. General Reimbursement Requirements. (1)(a) For the department to reimburse for a service or item, the service or item shall be:

1. Provided:

a. To a recipient under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21); and

b. By a provider who is:

(i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Authorized to provide the service in accordance with 907 KAR 1:038;

2. Covered in accordance with 907 KAR 1:038; and

3. Medically necessary.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(3) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(4)(a) If a provider receives any duplicate or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(5) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Hearing Program Fee Schedule; or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Hearing Program Fee Schedule.

Section 3. Audiology Service Reimbursement. The department shall reimburse a participating audiologist for an audiology service at the lesser of the:

(1) Audiologist's usual and customary charge for the service; or

(2) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the service.

Section 4. Hearing Instrument Reimbursement. (1) The department shall reimburse a participating specialist in hearing instruments or participating audiologist for a hearing instrument at

the lesser of the:

(a) Provider's usual and customary charge for the hearing instrument; or

(b) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the hearing instrument.

(2) A hearing examination of a recipient by a physician and a recommendation for a hearing instrument for the recipient by an audiologist shall:

(a) Be required for the department to cover a hearing instrument; and

(b) Occur prior to the fitting of a hearing instrument.

(3)(a) Except for an ear mold, an invoice for a hearing instrument, related supply, or accessory shall be submitted with the corresponding claim:

1. To the department; and

2. By the participating audiologist or participating specialist in hearing instruments who supplied the hearing instrument, related supply, or accessory.

(b) The department shall not require a participating audiologist or participating specialist in hearing instruments to submit an invoice for an ear mold.

Section 5. Ear Mold Reimbursement. (1) The department shall reimburse a participating audiologist or participating specialist in hearing instruments for an ear mold at the lesser of the:

(a) Provider's usual and customary charge for the ear mold; or

(b) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the ear mold.

(2) The department shall limit reimbursement for an ear mold, in conjunction with an ear examination, to:

(a) One (1) ear mold per six (6) month period for a child aged three (3) years or under; or

(b) One (1) ear mold per twelve (12) month period for a child who is at least four (4) years of age.

Section 6. Reimbursement for Hearing Instrument Batteries.

(1) The department shall reimburse a participating audiologist or participating specialist in hearing instruments for a hearing instrument battery at the lesser of the:

(a) Provider's usual and customary charge for the hearing instrument battery; or

(b) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the hearing instrument battery.

(2) The department's reimbursement for hearing instrument batteries shall be limited to fifty-two (52) batteries per hearing instrument when dispensed with a:

(a) New hearing instrument; or

(b) Replacement hearing instrument.

Section 7. Replacement Cord Reimbursement. The department shall reimburse a participating audiologist or participating specialist in hearing instruments for a replacement cord at the lesser of the:

(1) Provider's usual and customary charge for the replacement cord; or

(2) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the replacement cord.

Section 8. Hearing Instrument Repair Reimbursement. The department shall reimburse a participating audiologist or participating specialist in hearing instruments for hearing instrument repair at the lesser of the:

(1) Provider's usual and customary charge for the hearing instrument repair; or

(2) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the hearing instrument repair.

Section 9. Not Applicable to Managed Care Organizations. A

managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for a service or item covered pursuant to 907 KAR 1:038 and this administrative regulation.

Section 10. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 11. [Section 2. Reimbursement to an Audiologist. The department shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the department at sixty-five (65) percent of the median billed charge using 1989 calendar year billed charges.

Section 3. Hearing Instrument Reimbursement. (1) If a manufacturer of a hearing instrument billed to the department submits a price schedule which includes the manufacturer's invoice price of the hearing instrument, the department shall reimburse the participating specialist in hearing instruments at the lesser of:

(a) The manufacturer's invoice price plus a professional fee of:

1. \$150 for the first (one (1) ear) hearing instrument; and

2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date;

(b) The actual specialist in hearing instruments' cost plus a professional fee of:

1. \$150 for the first (one (1) ear) hearing instrument; and

2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date; or

(c) The suggested retail price submitted by the manufacturer for the hearing instrument.

(2) If a manufacturer of a hearing instrument billed to the department has not submitted a price schedule which includes the manufacturer's invoice price for the hearing instrument, the department shall reimburse the participating specialist in hearing instruments at the lesser of:

(a) The lowest price submitted for a comparable hearing instrument plus a professional fee of:

1. \$150 for the first (one (1) ear) hearing instrument; and

2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two

(2) hearing instruments are dispensed on the same date;

(b) The actual specialist in hearing instruments' cost plus a professional fee of:

1. \$150 for the first (one (1) ear) hearing instrument; and

2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date; or

(c) The lowest suggested retail price submitted by a manufacturer for a comparable instrument.

Section 4. Replacement Cord Reimbursement. The department shall reimburse for a replacement cord at the specialist in hearing instruments' cost plus a professional fee set at \$21.50.

Section 5. Hearing Instrument Repair Reimbursement. The department shall reimburse a specialist in hearing instruments for a hearing instrument repair:

(1) On the basis of the manufacturer's charge for repair or replacement of parts;

(2) Plus the specialist in hearing instruments' cost for postage and insurance relative to the repair;

(3) Plus a professional fee of \$21.50; and

(4) Not to exceed the price of a new hearing instrument.

Section 6.] Appeals. A provider may appeal a department

decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 12. Incorporation by Reference. (1) The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013, 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, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the reimbursement provisions for Medicaid hearing services and related.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws that require provision of hearing services for the Kentucky Medicaid recipients who are eligible for hearing 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 hearing service reimbursement provisions.

(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 hearing service reimbursement 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: The amendment establishes that the coverage provisions are contingent upon the receipt of federal approval and federal funding; inserts program integrity requirements and safeguards; incorporates by reference a Hearing Program Fee Schedule which lists covered CPT codes and HCPCS codes along with corresponding reimbursements; eliminates the prior upper payment limit which was sixty-five (65) percent of the median billed charge (for a service) using 1989 calendar year billed charges; eliminates reimbursement provisions that are now addressed on the aforementioned fee schedule; clarifies that an individual remains eligible for services in the month that they become twenty-one (21); inserts requirements that were previously stated in a hearing services manual; inserts ear mold, hearing instrument, and hearing instrument battery reimbursement limits. This administrative regulation is being promulgated simultaneously with a companion administrative regulation (907 KAR 1:038E, Hearing program coverage provisions and requirements) necessary to be promulgated at the same time as this administrative regulation.

(b) The necessity of the amendment to this administrative regulation: Establishing that the provisions are contingent upon the receipt of federal approval and federal funding is necessary to prevent Kentucky taxpayer funds from being spent if federal matching funds are not being provided. The program integrity requirements/safeguards are necessary to ensure appropriate utilization of services and to protect the health, safety, and welfare of Medicaid recipients. The upper payment limit amendment is necessary to equalize provider reimbursement among programs/provider types (physicians and audiologists); and incorporating the fee schedule offers providers a more reader-friendly mechanism for displaying reimbursement. This amended

administrative regulation is being promulgated simultaneously with a companion administrative regulation (907 KAR 1:038E, Hearing Program coverage provisions and requirements) as the companion administrative regulation adopts the same fee schedule incorporated by reference into this administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by preventing a potential loss of state funds, by enhancing program integrity requirements and safeguards for Medicaid recipients, and by equalizing provider reimbursement among programs and provider types.

(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the authorizing statutes by preventing a potential loss of state funds, by enhancing program integrity requirements and safeguards for Medicaid recipients, and by equalizing provider reimbursement among programs and provider types.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: For calendar year 2012, eleven (11) specialists in hearing instruments billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and sixty-nine (69) audiologists billed the Medicaid program. 3,510 individuals (managed care and fee-for-service combined) received services from specialists in hearing instruments in calendar year 2012 and 3,236 individuals (managed care and fee-for-service combined) received services from audiologists during the same period.

(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 necessary to comply with the amendment other than to properly bill for services and adhere to program integrity requirements.

(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 by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Providers should benefit from the fee schedule as it's a more reader-friendly mechanism with which to view reimbursement. Recipients may benefit from the enhanced program integrity requirements and safeguards.

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(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 matching state funds appropriated in the biennium budget.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied as audiology service coverage and hearing instrument coverage are limited to individuals under twenty-one (21) years of age as this is a component of mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services pursuant to 42 U.S.C. 1396d(r)(4) and 42 C.F.R. 441.56(c)(1).

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396d(r)(4), 42 U.S.C. 1396a(a)(30)(A), and 42 C.F.R. 441.56.

2. State compliance standards. KRS 194A.050(1) states, "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."

3. Minimum or uniform standards contained in the federal mandate. EPDST hearing coverage must include at least testing and diagnosis and treatment for hearing defects, including hearing aids. Hearing services must also be, "provided—

(i) At intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition." Additionally, Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

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. The requirements are not stricter.

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) is affected by the administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 441.56(c)1.

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 anticipates no additional revenue being generated by 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 additional revenue being generated by the amendment.

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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

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

STATEMENT OF EMERGENCY
907 KAR 1:044E

This emergency administrative regulation is being promulgated to comply with an Affordable Care Act mandate. The amendment to this administrative regulation is necessary to establish Kentucky Medicaid Program coverage and reimbursement of additional behavioral health services including substance use disorder services. The Department for Medicaid Services (DMS) currently covers substance use related services for pregnant women and children; however, the Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria.) This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Community Alternatives
(Emergency Amendment)

907 KAR 1:044E. Coverage provisions and requirements regarding community mental health center services.

RELATES TO: KRS 194A.060, 205.520(3), 205.8451(9), 422.317, 434.840-434.860, 42 C.F.R. 415.208, 431.52, 431 Subpart F

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 210.450, 42 U.S.C. 1396a-d

EFFECTIVE: December 30, 2013

NECESSITY, FUNCTION, AND CONFORMITY: 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 any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[for the provision of medical assistance to

~~Kentucky's indigent citizenry~~]. This administrative regulation establishes the coverage provisions and requirements regarding ~~for~~ community mental health center (CMHC) services.

Section 1. Definitions. (1) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

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

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

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

(5) "Provider" is defined by KRS 205.8451(7).

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

Section 2. Requirements for a Psychiatric Nurse. A registered nurse employed by a participating community mental health center shall be considered a psychiatric or mental health nurse if the individual~~he or she~~:

(1) Possesses a master of science in nursing with a specialty in psychiatric or mental health nursing;

(2)(a) Is a graduate of a four (4) year nursing educational program with a bachelor of science in nursing; and

(b) Possesses at least one (1) year of experience in a mental health setting;

(3)(a) Is a graduate of a three (3) year nursing educational program; and

(b) Possesses at least two (2) years of experience in a mental health setting;

(4)(a) Is a graduate of a two (2) year nursing educational program with an associate degree in nursing; and

(b) At least three (3) years of experience in a mental health setting; or

(5) Possesses any level of education with American Nursing Association certification as a psychiatric or mental health nurse.

Section 3. Community Mental Health Center Services Manual. The conditions for participation, services covered, and limitations for the community mental health center services component of the Medicaid Program shall be as specified in:

(1) This administrative regulation; and

(2) The Community Mental Health Center Services Manual.

Section 4. Covered Services. (1) Services covered pursuant to this administrative regulation and pursuant to the Community Mental Health Center Services Manual shall include:

(a) Inpatient services;

(b) Outpatient Services;

(c) Individual therapy;

(d) Group therapy;

(e) Family therapy;

(f) Collateral services including collateral therapy;

(g) Intensive in-home services;

(h) Home visits;

(i) Emergency services;

(j) Personal care home services;

(k) Therapeutic rehabilitation services for adults;

(l) Therapeutic rehabilitation services for children;

(m) Evaluations, examinations, and testing including psychological testing;

(n) Physical examinations;

(o) Services in a detoxification setting;

(p) Chemotherapy services;

(q) Screening;

(r) An assessment;

(s) Crisis intervention;

(t) Service planning;

(u) A screening, brief intervention, and referral to treatment;

(v) Medication assisted treatment for a substance use disorder;

(w) Mobile crisis services;

(x) Assertive community treatment;

(y) Intensive outpatient program services;

- (z) Residential crisis stabilization services;
- (aa) Partial hospitalization;
- (bb) Residential services for substance use disorders;
- (cc) Day treatment;
- (dd) Comprehensive community support services;
- (ee) Peer support services; or
- (ff) Parent or family peer support services.

(2)(a) To be covered under this administrative regulation, a service listed in subsection (1) of this section shall be [inpatient services, outpatient services, therapeutic rehabilitation services, emergency services and personal care home services shall be covered if the service]:

1. [(1)-(1s)] Provided by a community mental health center that is:

- a. Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672; and

- b. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and

2. [; and

(2)-(1s)] Provided in accordance with:

- a. This administrative regulation; and

- b. The Community Mental Health Center Services Manual.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 5. Electronic Documents and Signatures. (1) The creation, transmission, storage, or other use of electronic signatures and documents shall comply with requirements established in KRS 369.101 to 369.120 and all applicable state and federal laws and regulations.

(2) A CMHC choosing to utilize electronic signatures shall:

(a) Develop and implement a written security policy which shall:

- 1. Be complied with by each of the center's employees, officers, agents, and contractors; [and]

- 2. Stipulate which individuals have access to which electronic signatures and password authorization; and

- 3. Identify each electronic signature for which an individual has access; [;]

- (b) Ensure that electronic signatures are created, transmitted and stored securely; [and]

(c) Develop a consent form which shall:

- 1. Be completed and executed by each individual utilizing 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

(d) 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 6. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independently enrolled behavioral health service provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a community mental health center.

Section 7. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2) A health record shall:

(a) Include:

- 1. An identification and intake record including:

- a. Name;

- b. Social Security number;

- c. Date of intake;

- d. Home (legal) address;

- e. Health insurance information;

- f. Referral source and address of referral source;

- g. Primary care physician and address;

- h. The reason the individual is seeking help including the presenting problem and diagnosis;

- i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:

- (i) Where the individual is receiving treatment for the physical health diagnosis; and

- (ii) The physical health provider; and

- j. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

- (i) This administrative regulation;

- (ii) The provider's licensure board;

- (iii) State law; or

- (iv) Federal law;

2. Documentation of the:

- a. Screening;

- b. Assessment;

- c. Disposition; and

- d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;

- 3. A complete history including mental status and previous treatment;

- 4. An identification sheet;

- 5. A consent for treatment sheet that is accurately signed and dated; and

- 6. The individual's stated purpose for seeking services;

- (b) Be:

- 1. Maintained in an organized central file;

- 2. Furnished to the Cabinet for Health and Family Services upon request;

- 3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;

- 4. Readily accessible; and

- 5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient; and

- (c) Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

- (3) The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

- (4)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

- (b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

- (5) A provider shall comply with 45 C.F.R. Part 164.

- (6) Documentation of a screening shall include:

- (a) Information relative to the individual's stated request for services; and

- (b) Other stated personal or health concerns if other concerns are stated.

- (7)(a) A provider's notes regarding a recipient shall:

- 1. Be made within forty-eight (48) hours of each service visit; and

- 2. Describe the:

- a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

- b. Therapist's intervention;

- c. Changes in the treatment plan if changes are made; and

- d. Need for continued treatment if continued treatment is needed.

- (b)1. Any edit to notes shall:

- a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional providing the service.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(8) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) An appropriate diagnosis;

(b) A referral for further consultation and disposition, if applicable; and

(c)1. Termination of services and referral to an outside source for further services; or

2. Termination of services without a referral to further services.

(9)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.

(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.

(10)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Dated;

3. Titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(11)(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

2. Contain a summary of the significant findings and events during the course of treatment including the:

a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

b. Final diagnosis of clinical impression; and

3. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(12) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(13) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient.

(14)(a) If a provider's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records of the provider shall:

1. Remain the property of the provider; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A provider shall have a written plan addressing how to maintain health records in the event of the provider's death.

Section 8. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 9. Provider Eligibility. (1) To be eligible to provide, and be reimbursed, for a service pursuant to this administrative regulation, a community mental health center shall be:

(a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

(b) Except as established in subsection (2) of this section, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671.

(2) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 10. Third Party Liability. A provider shall comply with KRS 205.622.

Section 11. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 12. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 13. Appeal Rights. (1) An appeal of an adverse action by the[a] department [decision] regarding a [Medicaid] recipient who is not enrolled with a managed care organization [based upon an application of this administrative regulation] shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:674].

Section 14.[7.] Incorporation by Reference. (1) The "Community Mental Health Center Services Manual", December 2013[January-2008 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, 6th Floor West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office

of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program community mental health center (CMHC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program CMHC 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 coverage provisions and requirements regarding Medicaid Program CMHC 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 authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program CMHC 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 primary amendment authorizes CMHC to provide substance use disorder services (to all Medicaid recipients in contrast to the current scope of coverage which only includes pregnant women) and expands the scope of behavioral health services covered in a CMHC. Additional amendments include inserting various program integrity requirements such as requiring CMHCs to bill third parties for services if a third party is involved and not duplicate bill for a service provided to the recipient by another provider. Other amendments include establishing that CMHCs must comply with records maintenance/security requirements and Medicaid provider participation requirements. Another section is added to establish that the coverage of CMHC services is contingent upon federal approval and federal funding. Also, a section is added that clarifies that the Department for Medicaid Services has the authority to audit any claim, medical record, or documentation associated with any claim or medical record. Lastly, the appeals section is revised to establish that appeal rights regarding an adverse action in the realm of managed care will be as established in the relevant managed care organization administrative regulation (907 KAR 17:010, Managed care organization requirements and policies relating to enrollees.)

(b) The necessity of the amendment to this administrative regulation: The primary amendment – amendment related to substance use disorder services and behavioral health services – is necessary to comply with a federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." Additionally, the Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange. The Medicaid Program is required to

ensure that recipients have access to services. Other amendments are necessary to enhance program integrity requirements, establish that provisions and requirements are contingent upon federal funding (in order to protect state taxpayer generated funds), and clarify appeal rights for Medicaid recipients.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(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 complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Community mental health centers will be affected by this amendment. Additionally, licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide substance use disorder services or the enhanced behavioral health services (established in this amendment) while working for or under contract with CMHC will also be affected by this administrative regulation. Medicaid recipients who qualify for substance use disorder services or the enhanced scope of behavioral health services will be affected by this amendment.

(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. CMHCs will need to ensure that they use the practitioners authorized in this administrative regulation (stated in the incorporated material) to provide the new scope of services (expanded behavioral health services and substance use disorder services) if the given CMHCs wish to expand their scope of services accordingly.

(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 anticipated as expanding the scope of services is voluntary.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). CMHCs will benefit by being authorized to provide more services. The expanded types of behavioral health practitioners/professionals will benefit by having more employment opportunities in which to provide services. Medicaid recipients will benefit by having enhanced access to behavioral health services including substance use disorder services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services, including substance use disorder services, covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such

services could reduce Medicaid program expenditures in aggregate.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2).

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

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 the amendment to this administrative regulation as will any community mental health center owned by a local government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many community mental health centers that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid Program expenditures in aggregate.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

**STATEMENT OF EMERGENCY
907 KAR 1:045E**

This emergency administrative regulation is being promulgated in conjunction with a companion administrative regulation – 907 KAR 1:044E, Coverage and provisions regarding community mental health center services - to comply with an Affordable Care Act mandate. The amendment to this administrative regulation is necessary to establish Kentucky Medicaid Program reimbursement of additional behavioral health services including substance use disorder services. The Department for Medicaid Services (DMS) currently covers substance use related services for pregnant women and children; however, the Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria.) This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

**CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Community Alternatives
(Emergency Amendment)**

907 KAR 1:045E. Reimbursement provisions and requirements regarding ~~Payments for~~ community mental health center services.

RELATES TO: KRS 205.520(3), 210.370

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 447.325, 42 U.S.C. 1396a-d

EFFECTIVE: December 30, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the program of Medical Assistance. 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 ~~for the provision of medical assistance to Kentucky's indigent citizenry~~. This administrative regulation establishes the reimbursement provisions and requirements regarding ~~method for determining amounts payable by the Medicaid Program for~~ community mental health center services provided to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. Definitions. (1) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

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

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Managed care organization" 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.

(6) "Provider" is defined by KRS 205.8451(7).

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

Section 2. General Reimbursement Provisions. (1) The department shall reimburse ~~a~~ Community Mental Health Centers participating in-state community mental health center ~~centers shall be reimbursed~~ as established in this subsection. ~~follows:~~

(a) ~~(1)~~ Effective July 1, 2005] The payment rate that was in effect on June 30, 2002, for the community mental health center for community mental health center services shall remain in

effect ~~throughout state fiscal year (SFY) 2006~~ and there shall be no cost settling.

(b) ~~(2)~~ Allowable costs shall not:

1. Exceed customary charges which are reasonable;

2. ~~(a) Allowable costs shall not~~ Include:

a. ~~(1-)~~ The costs associated with political contributions;

b. ~~(2-)~~ Travel or related costs for trips outside the state (for purposes of conventions, meetings, assemblies, conferences, or any related activities);

c. ~~(3-)~~ The costs of motor vehicles used by management personnel which exceed \$20,000 total valuation annually (unless the excess cost is considered as compensation to the management personnel); or

d. ~~(4-)~~ Legal fees for unsuccessful lawsuits against the cabinet.

~~(c) [(b)]~~ Costs (excluding transportation costs) for training or educational purposes outside the state shall be allowable costs.

(2) To be reimbursable, a service shall be:

(a) Provided:

1. By a CMHC:

a. That is currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

b. Except as established in subsection (3) of this section, that is currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and

2. To a recipient;

(b) Medically necessary; and

(c) A covered CMHC service pursuant to 907 KAR 1:044.

(3) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 3. ~~(2-)~~ Implementation of Payment System. (1) ~~(a)~~ Payments shall be based on units of service.

(b) One (1) unit for each service shall be defined as follows:

Service	Unit of Service
Inpatient Service	15 minutes
Outpatient Service	15 minutes
Individual Therapy	15 minutes
Group Therapy	15 minutes
Family Therapy	15 minutes
Collateral Therapy	15 minutes
Intensive In-Home Services [Therapy]	15 minutes
Home Visit Service	15 minutes
Emergency Service	15 minutes
Personal Care Home Service	15 minutes
Evaluations, Examinations, and Testing including Psychological Testing	15 minutes
Therapeutic Rehabilitation for Children	1 hour
Therapeutic Rehabilitation for Adults	1 hour
Chemotherapy Service	15 minutes
Physical Examinations	15 minutes
Services in a Detoxification Setting	15 minutes
Screening	15 minutes
Assessment	15 minutes
Crisis Intervention	15 minutes
Service Planning	15 minutes
Screening, Brief Intervention, and Referral to Treatment	15 minutes
Medication Assisted Treatment for a Substance Use Disorder	15 minutes
Mobile Crisis Services	15 minutes
Assertive Community Treatment	15 minutes
Intensive Outpatient Program Services	15 minutes
Residential Crisis Stabilization Services	15 minutes
Residential Services for Substance Use Disorders	15 minutes
Partial Hospitalization	15 minutes
Day Treatment	15 minutes
Comprehensive Community Support Services	15 minutes

Peer Support Services	15 minutes
Parent or Family Peer Support Services	15 minutes

(2) An initial unit of service which lasts less than fifteen (15) minutes may be billed as one (1) unit.

(3) Except for an initial unit of a service, a service that is:

(a) Less than one-half (1/2) of one (1) unit shall be rounded down; or

(b) Equal to or greater than one-half (1/2) of one (1) unit shall be rounded up.

(4) An individual provider shall not exceed four (4) units of service in one (1) hour.

(5) An overpayment[Overpayments] discovered as a result of an audit[audit] shall be settled through recoupment or withholding.

(6) A community mental health center[The vendor] shall:

(a) Complete an annual cost report on forms provided by the department [cabinet]—[and included in the Community Mental Health Center[Intellectual Disability] Reimbursement Manual];

(b) No[not] later than ninety (90) days from the end of the community mental health center's[vendor's] accounting year, submit the cost report to the department; and

(c)[the vendor shall] Maintain an acceptable accounting system to account for:

1. The cost of total services provided;

2.[.] Charges for total services rendered[.] and

3. Charges for covered services rendered eligible recipients.

(7) A[Each] community mental health center shall make available to the department all recipient records and fiscal records:

(a)[cabinet] At the end of each fiscal reporting period;

(b) Upon request by[.] and at intervals as the department; and

(c)[cabinet may require, all patient and fiscal records of the provider.] Subject to reasonable prior notice by the department[cabinet].

(8) Payments due a community mental health center shall be made at least once a month[reasonable intervals but not less often than monthly].

Section 4.[3.] Nonallowable Costs. The department[cabinet] shall not reimburse:

(1)[make reimbursement] Under the provisions of this administrative regulation for a service that is[.] services not covered by 907 KAR 1:044; or

(2) For[.] mental health center services, nor for that portion of a community mental health center's costs found unreasonable or nonallowable in accordance with the [.]Community Mental Health Center[Intellectual Disability] Reimbursement Manual[.]

Section 5.[4.] Reimbursement of Out-of-state Providers. Reimbursement to a participating out-of-state community mental health center[centers] shall be the:

(1) Lower of charges;

(2)[.] or the Facility's rate as set by the state Medicaid Program in the other state[.] or

(3)[the] Upper limit for that type of service in effect for Kentucky providers.

Section 6.[5.] Appeal Rights. A community mental health center[provider] may appeal a Department for Medicaid Services decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 7.[6.] Not Applicable to Managed Care Organization. A managed care organization shall not be required to reimburse for community mental health center services in accordance with this administrative regulation.

Section 8. Federal Approval. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for

the reimbursement.

Section 9. Incorporation by Reference. (1) The "Community Mental Health Center[Intellectual Disability] Reimbursement Manual", December 2013[July 2005 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., or 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 27, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid Program reimbursement provisions and requirements regarding community mental health center (CMHC) services. CMHCs operate under the authority of regional community mental health boards [there are fourteen (14) in Kentucky] - in accordance with KRS 210.370 through KRS 210.485 - and are licensed and regulated by the Cabinet for Health and Family Services, Office of Inspector General.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Kentucky Medicaid program reimbursement provisions and requirements regarding CMHC 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 Kentucky Medicaid program reimbursement provisions and requirements regarding CMHC 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 authorizing statutes by establishing the Kentucky Medicaid program reimbursement provisions and requirements regarding CMHC 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 adds reimbursement for services (added to companion administrative regulation 907 KAR 1:044, Community mental health center services) not previously included in the scope of Medicaid CMHC services. Among the new services are substance use disorder services for all ages/categories of Medicaid recipients. Previously, the Department for Medicaid Services (DMS) only covered substance use treatment for pregnant women and children. The amendment also adds other new behavioral health services not previously covered by the Medicaid program and clarifies that the reimbursement rates for CMHC services remains in effect at the same level.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to establish reimbursement for new services being added to the scope of CMHC services covered by the Medicaid Program including substance use disorder services for all ages/categories of Medicaid recipients. Previously, the Department for Medicaid Services (DMS) only covered substance use treatment for pregnant women and children; however, the Affordable Care Act mandates Medicaid coverage of substance use disorder services for all; thus, the amendment is necessary to comply with a federal mandate.

(c) How the amendment conforms to the content of the

authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with a federal mandate.

(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 complying with a federal mandate.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The amendment applies to all CMHCs. There are currently fifteen (15) CMHCs participating in the Medicaid Program. 73,779 Medicaid recipients received CMHC services during the course of the state fiscal year that ended June 30, 2013 with CMHCs receiving a total of \$21.9 million from DMS for the services and \$38.86 million from managed care organizations for the 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. No compliance action is mandated.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This amendment imposes no cost on the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): CMHCs will benefit by reimbursed for more services covered by the Medicaid program and recipients will benefit by having access to more CMHC services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services, including substance use disorder services, covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid program expenditures in aggregate.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 will be necessary to implement the amendment to this administrative regulation.

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

(9) Tiering: Is tiering applied? Tiering is not applied as the amendment applies to all regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30) and 42 C.F.R. 447.204.

2. State compliance standards. KRS 205.520(3) states, "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. 42 U.S.C. 1396a(a)(30) requires Medicaid program payments to be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the same geographic area. 42 C.F.R. 447.204 requires Medicaid reimbursement to be sufficient to enlist enough providers to ensure that services are available to Medicaid recipients at least to the extent that they are available to the general population.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The policy is not stricter than the federal standard.

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 the amendment to this administrative regulation as will any community mental health center owned by a local government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many community mental health centers that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid program expenditures in aggregate.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY
907 KAR 1:054E

This emergency administrative regulation is being promulgated to comply with an Affordable Care Act mandate. The amendment to this administrative regulation is necessary to establish Kentucky Medicaid Program coverage and reimbursement of additional behavioral health services including substance use disorder services. The Department for Medicaid Services (DMS) currently covers substance use related services for pregnant women and children; however, the Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria.) Additionally, DMS is expanding the base of behavioral health providers to ensure that there is an adequate supply of providers to meet Medicaid recipient demand for care – as federally required. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Emergency Amendment)

907 KAR 1:054E. Coverage provisions and requirements regarding federally-qualified health center services, federally-qualified health center look-alike services, and primary care center [and federally-qualified health center] services.

RELATES TO: KRS 205.520, 310.005, 314.011, 335.100, 42 C.F.R. 400.203, 405.2401, 2412-2416, 2446, 2448, 2450, 2452, 441 Subpart E and F, 447.53, 42 U.S.C. 1395x(aa), 42 U.S.C. 1396d

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

EFFECTIVE: December 30, 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program coverage provisions and requirements relating to primary care center and federally-qualified health center services[for which payment shall be made by the Medicaid Program on behalf of both the categorically-needy and medically-needy].

Section 1. Definitions. (1) "Advanced practice registered nurse[practitioner]" is defined by KRS 314.011(7).

(2) "Certified social worker" means an individual who:

- (a) Meets the requirements established in KRS 335.080; and
- (b) Has at least a master's degree in social work.

(3) "Clinical pharmacist" means a licensed pharmacist whose scope of service includes taking medication histories, monitoring drug use, contributing to drug therapy, drug selection, patient counseling, administering drug programs, or surveillance for adverse reactions and drug interactions.

(4)[(3)] "Clinical psychologist" means a doctorate level psychologist who is licensed in accordance with KRS 319.050.

(5) "Club house model of psychosocial rehabilitation" means a form of psychosocial rehabilitation that focuses on self-help, friendship, emotional support, acceptance, and meaningful and gainful employment.

(6) "Community support associate" means an individual who meets the community support associate requirements established

in 908 KAR 2:250.

(7)[(4)] "Department" means the Department for Medicaid Services or its designee.

(8)[(5)] "Emergency condition" means a condition or situation requiring an emergency service pursuant to 42 C.F.R. 447.53.

(9) "Enrollee" means a recipient who is enrolled with a managed care organization.

(10) "Face-to-face" means occurring:

- (a) In person; or
- (b) Via a real-time, electronic communication that involves two (2) way interactive video and audio communication.

(11) "Family peer support specialist" means an individual who meets the requirements for a Kentucky family peer support specialist established in 908 KAR 2:230.

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

(13)[(6)] "Federally-qualified health center" or "FQHC" is defined by 42 U.S.C. 1396d(l)(2)(B).

(14) "Federally-qualified health center look-alike" or "FQHC look-alike" means an entity that is currently approved by the United States Department of Health and Human Services, Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services to be a federally-qualified health center look-alike.

(15) "Fountain House" means the professional self-help program located in New York City about which information is available on the Web site of <http://www.fountainhouse.org/>.

(16)[(7)] "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(17) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(18) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(19) "Licensed professional counselor associate" is defined by KRS 335.500(3).

(20) "Licensed psychological associate" means an individual who:

- (a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and
- (b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.

(21) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(22) "Licensed psychologist" means an individual who:

- (a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and
- (b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

(23) "Managed care organization" 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.

(24) "Marriage and family therapy associate" is defined by KRS 335.300(3).

(25) "Medically necessary" means that a covered benefit or service is necessary in accordance with 907 KAR 3:130.

(26)[(8)] "Nurse-midwife" is defined by 42 C.F.R. 405.2401(b).

(27)[(9)] "Nutritionist" is defined by KRS 310.005(4).

(28) "Peer support specialist" means an individual who meets the peer specialist qualifications established in 908 KAR 2:220.

(29)[(10)] "Physician" is defined by KRS 205.510(11) and 42 C.F.R. 405.2401(b).

(30)[(11)] "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(31)[(12)] "Primary care center" or "PCC" means an entity meeting the primary care center requirements established in 902 KAR 20:058.

(32) "Qualified mental health professional" is defined by KRS 202A.011(12).

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

(34)[(13)] "State plan" is defined by 42 C.F.R. 400.203.

(35) "Youth peer support specialist" means an individual who meets the requirements established for a Kentucky youth peer

support specialist established in 908 KAR 2:240.

Section 2. Primary Care Center Covered Services Other Than Behavioral Health Services. (1) The department shall cover, and a primary care center shall provide, the following services:

- (a) Medical diagnostic or treatment services provided by a physician, advanced registered nurse practitioner, or a physician assistant if licensed under state authority;
- (b) Treatment of injuries or minor trauma;
- (c) Prenatal or postnatal care;
- (d) Preventive health services including well-baby care, well-child care, immunization, or other preventive care;
- (e) Referral services designed to ensure the referral to and acceptance by an appropriate medical resource if services necessary to the health of the patient are not provided directly by the center; and

(f) Health education, including distribution of written material, provided by appropriate personnel to local school systems, civic organizations, or other concerned local groups.

(2) The department shall cover the following services and a primary care center shall provide at least two (2) of the following services:

- (a) Dental services;
- (b) Optometric services;
- (c) Family planning services listed and as limited in 907 KAR 1:048;
- (d) Home health services listed and as limited in 907 KAR 1:030;
- (e) Social services counseling;
- (f) Pharmacy services which shall meet the coverage criteria established in 907 KAR 1:019;

(g) Nutritional services provided by a nutritionist, including individual counseling relating to nutritional problems or nutritional education or group nutritional services; or

(h) Nurse midwifery services which shall be provided:

- 1. As a program including prenatal services to expectant mothers, delivery or postnatal services; and
- 2. By a nurse midwife.

(3) The department shall cover, and a primary care center may provide the following services:

- (a) Excluding institutional care, other state plan services;
- (b) Holding or observation accommodations;
- (c) Outreach services provided as a package structured to identify health care needs in the service area;
- (d) Clinical pharmacist services; or
- (e) ~~Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced registered nurse practitioner within the provider's legally authorized scope of service;~~

(f) Services or supplies furnished as an incident to services provided by a physician, physician assistant, advanced practice registered nurse [practitioner], or nurse midwife if the service or supply meets the criteria established in 42 C.F.R. 405.2413 or 42 C.F.R. 405.2415; or

(g) ~~Services or supplies incidental to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in 42 C.F.R.]~~

Section 3. Federally-Qualified Health Center and Federally-Qualified Health Center Look-Alike Covered Services Other Than Behavioral Health Services. A federally-qualified health center shall provide:

- (1) Federally-qualified health center services pursuant to 42 U.S.C. 1395x(aa)(3);
- (2) Federally-qualified health center services pursuant to 42 U.S.C. 1396d(l)(2)(A);
- (3) Other Medicaid-covered ambulatory outpatient services established in the state plan; or
- (4) Any combination of the services described in subsections (1), (2), and (3) of this section.

Section 4. Primary Care Center, Federally-Qualified Health Center, and Federally-Qualified Health Center Look-Alike Covered

Behavioral Health Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for a:

- (a) Mental health disorder;
- (b) Substance use disorder; or
- (c) Co-occurring mental health and substance use disorders.

(2) The department shall cover, and a primary care center, federally-qualified health center, or federally-qualified health center look-alike may provide, the following services:

(a) Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced registered nurse practitioner within the provider's legally authorized scope of service; or

(b) Services or supplies incidental to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in 42 C.F.R. 405.2452.

(3) In addition to the services referenced in subsection (2) of this section, the following behavioral health services provided by a primary care center, federally-qualified health center, or federally-qualified health center look-alike shall be covered under this administrative regulation in accordance with the corresponding following requirements:

(a) A screening provided by:

- 1. A licensed psychologist;
- 2. A licensed professional clinical counselor;
- 3. A licensed clinical social worker;
- 4. A licensed marriage and family therapist;
- 5. A physician;
- 6. A psychiatrist;
- 7. An advanced practice registered nurse;
- 8. A licensed psychological practitioner;
- 9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(b) An assessment provided by:

- 1. A licensed psychologist;
- 2. A licensed professional clinical counselor;
- 3. A licensed clinical social worker;
- 4. A licensed marriage and family therapist;
- 5. A physician;
- 6. A psychiatrist;
- 7. An advanced practice registered nurse;
- 8. A licensed psychological practitioner;
- 9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(j) A screening, brief intervention, and referral to treatment for a substance use disorder provided by:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(k) Medication assisted treatment for a substance use disorder provided by:

1. A physician; or
2. A psychiatrist;

(l) Day treatment provided by a team of at least two (2) of the following:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of

a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(m) Comprehensive community support services provided by a team of at least two (2) of the following:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional;

16. A youth peer support specialist working under the supervision of a mental health professional; or

17. A community support associate;

(n) Peer support provided by:

1. A peer support specialist working under the supervision of a mental health professional;

2. A family peer support specialist working under the supervision of a mental health professional; or

3. A youth peer support specialist working under the supervision of a mental health professional;

(o) Mobile crisis services provided by a team of at least two (2) of the following:

1. A licensed psychologist;
2. A licensed professional clinical counselor;
3. A licensed clinical social worker;
4. A licensed marriage and family therapist;
5. A physician;
6. A psychiatrist;
7. An advanced practice registered nurse;
8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional; or

(u) Parent or family peer support provided by:

1. A peer support specialist working under the supervision of a mental health professional;

2. A family peer support specialist working under the supervision of a mental health professional; or

3. A youth peer support specialist working under the supervision of a mental health professional.

(4)(a) A screening shall:

1. Be the determination of the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorder;

2. Not establish the presence or specific type of disorder; and

3. Establish the need for an in-depth assessment.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the provider to:

a. Establish the presence or absence of a mental health disorder or substance use disorder;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinic disorder or service need;

3. Include working with the individual to develop a treatment and service plan; and

4. Not include a psychological or psychiatric evaluation or assessment.

(c) Psychological testing shall include:

1. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and

2. Interpretation and a written report of testing results.

(d) Crisis intervention:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:

a. The recipient; or

b. Another individual;

2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for an individual with a behavioral health disorder;

3. Shall be provided:

a. In an office, home, or community setting where the individual is experiencing the crisis;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one-on-one encounter between the provider and the recipient;

4. May include verbal de-escalation, risk assessment, or cognitive therapy; and

5. Shall be followed by a referral to noncrisis services if applicable.

(e)1. Service planning shall consist of assisting a recipient in creating an individualized plan for services needed to maintain functional stability or return to stability as soon as possible in order to avoid out-of-home care.

2. A service plan:

a. Shall be directed by the recipient; and

b. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

(f) Individual outpatient therapy shall:

1. Be provided to promote the:

a. Health and wellbeing of the individual; or

b. Recovery from a substance related disorder;

2. Consist of:

a. A face-to-face, one-on-one encounter between the provider and recipient; and

b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

a. Reducing adverse symptoms;

b. Reducing or eliminating the presenting problem of the recipient; and

c. Improving functioning; and

4. Not exceed three (3) hours per day.

(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

(h)1. Group outpatient therapy shall:

a. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Recovery from a substance related disorder;

b. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

c. Be provided to a recipient in a group setting:

(i) Of nonrelated individuals; and

(ii) Not to exceed eight (8) individuals in size;

d. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

e. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and

f. Not exceed three (3) hours per day.

2. The group shall have a:

a. Deliberate focus; and

b. Defined course of treatment.

3. The subject of a group receiving group outpatient therapy shall be related to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.

(i)1. Collateral outpatient therapy shall:

a. Consist of a face-to-face behavioral health consultation:

(i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and

(ii) That is provided in accordance with the recipient's treatment plan; and

b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age.

2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.

(j) Screening, brief intervention, and referral to treatment for a substance use disorder shall:

1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and

2. Consist of:

a. Using a standardized screening tool to assess an individual for risky substance use behavior;

b. Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and

c. Referring a recipient to:

(i) Therapy; or

(ii) Other additional services to address substance use if the recipient is determined to need other additional services.

(k) Medication assisted treatment for a substance use disorder:

1. Shall include:

a. Any opioid addiction treatment that includes a United States Food and Drug Administration-approved medication for the detoxification or maintenance treatment of opioid addiction along with counseling or other supports;

b. Comprehensive maintenance;

c. Medical maintenance;

d. Interim maintenance;

e. Detoxification; or

f. Medically supervised withdrawal;

2. May be provided in:

a. An opioid treatment program;

b. A medication unit affiliated with an opioid treatment program;

c. A physician's office; or

d. Other community setting; and

3. Shall increase the likelihood for cessation of illicit opioid use or prescription opioid abuse.

(l) 1. Day treatment shall be a nonresidential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:

a. An emotional disability or neurobiological or substance use disorder; and

b. A high risk of out-of-home placement due to a behavioral health issue.

2. Day treatment services shall:

a. Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorder);

b. Have unified policies and procedures that:

(i) Address the program philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning; and

(ii) Have been approved by the recipient's local education authority and the day treatment provider;

c. Include:

(i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

(ii) Behavior management and social skill training;

(iii) Independent living skills that correlate to the age and development stage of the recipient; or

(iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and

d. Be provided:

(i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);

(ii) On school days and during scheduled breaks;

(iii) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;

(iv) Under the supervision of a licensed or certified behavioral health practitioner or a behavioral health practitioner working under clinical supervision; and

(v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.

3. To provide day treatment services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. The capacity to employ staff authorized to provide day treatment services in accordance with subsection (3)(l) of this section and to coordinate the provision of services among team

members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in subparagraph 1 of this paragraph;

c. Demonstrated experience in serving individuals with behavioral health disorders;

d. The administrative capacity to ensure quality of services;

e. A financial management system that provides documentation of services and costs;

f. The capacity to document and maintain individual case records; and

g. Knowledge of substance use disorders.

4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.

(m) 1. Comprehensive community support services shall:

a. Be activities necessary to allow an individual to live with maximum independence in community-integrated housing;

b. Be intended to ensure successful community living through the utilization of skills training, cueing, or supervision as identified in the recipient's treatment plan;

c. Include:

(i) Reminding a recipient to take medications and monitoring symptoms and side effects of medications; or

(ii) Teaching parenting skills, teaching community resource access and utilization, teaching emotional regulation skills, teaching crisis coping skills, teaching how to shop, teaching about transportation, teaching financial management, or developing and enhancing interpersonal skills; and

d. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

3. To provide comprehensive community support services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. The capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (3)(m) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;

c. Demonstrated experience in serving individuals with behavioral health disorders;

d. The administrative capacity to ensure quality of services;

e. A financial management system that provides documentation of services and costs; and

f. The capacity to document and maintain individual case records.

(n) 1. Peer support services shall:

a. Be social and emotional support that is provided by an individual who is experiencing a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified consumer or parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:220;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide peer support services, an FQHC, an FQHC look-alike, or a PCC shall:

a. Have demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ peer support specialists who are qualified to provide

peer support services in accordance with 908 KAR 2:220;

c. Use a qualified mental health professional to supervise peer support specialists;

d. Have the capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (3)(n) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(o)1. Mobile crisis services shall:

a. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the year; and

b. Be a crisis response in a home or community setting to provide an immediate evaluation, triage, and access to acute substance use disorder services including treatment and supports to:

(i) Reduce symptoms or harm; or

(ii) Safely transition an individual in an acute crisis to appropriate crisis stabilization and detoxification supports or services.

2. To provide mobile crisis services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. The capacity to employ staff authorized to provide mobile crisis services in accordance with subsection (3)(o) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;

c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;

d. Demonstrated experience in serving individuals with behavioral health disorders;

e. The administrative capacity to ensure quality of services;

f. A financial management system that provides documentation of services and costs;

g. The capacity to document and maintain individual case records; and

h. Knowledge of substance use disorders.

(p)1. Assertive community treatment shall:

a. Be an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for individuals with a serious mental illness;

b. Use a multidisciplinary team of at least two (2) of the following professionals:

(i) A psychiatrist;

(ii) A nurse;

(iii) A case manager; or

(iv) A therapist; and

c. Include:

(i) Assessment;

(ii) Treatment planning;

(iii) Case management;

(iv) Psychiatric services;

(v) Medication management administration;

(vi) Individual outpatient therapy;

(vii) Family outpatient therapy;

(viii) Group outpatient therapy;

(ix) Mobile crisis intervention;

(x) Mental health consultation; or

(xi) Family support and basic living skills.

2. To provide assertive community treatment services, an FQHC, an FQHC look-alike, or a PCC shall:

a. Employ one (1) or more teams:

(i) Led by a qualified mental health professional; and

(ii) Comprised of at least four (4) full-time equivalents including a prescriber, a nurse, a qualified mental health professional, a case manager, or a co-occurring disorder specialist;

b. Have adequate staffing to ensure that no caseload size exceeds ten (10) participants per team member;

c. Have the capacity to employ staff authorized to provide assertive community treatment services in accordance with subsection (3)(p) of this section and to coordinate the provision of services among team members;

d. The capacity to provide the full range of assertive community treatment services as stated in this paragraph;

e. Demonstrated experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community;

f. The administrative capacity to ensure quality of services;

g. A financial management system that provides documentation of services and costs; and

h. The capacity to document and maintain individual case records.

(q)1. Intensive outpatient program services shall:

a. Be an alternative to inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;

b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy; and

c. Be provided at least three (3) hours per day at least three (3) days per week; and

d. Include:

(i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless contraindicated;

(ii) Crisis intervention; or

(iii) Psycho-education.

2. During psycho-education, the recipient or family member shall be:

a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and

b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

3. An intensive outpatient program treatment plan shall:

a. Be individualized; and

b. Focus on stabilization and transition to a lesser level of care.

4. To provide intensive outpatient program services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. Access to a board-certified or board-eligible psychiatrist for consultation;

b. Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;

c. Adequate staffing to ensure a minimum recipient-to-staff ratio of four (4) clients to one (1) recipient;

d. The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;

e. The capacity to employ staff authorized to provide intensive outpatient program services in accordance with subsection (3)(q) of this section and to coordinate the provision of services among team members;

f. The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;

g. Demonstrated experience in serving individuals with behavioral health disorders;

h. The administrative capacity to ensure quality of services;

i. A financial management system that provides documentation of services and costs; and

j. The capacity to document and maintain individual case records.

(r)1. Residential crisis stabilization services shall be provided in a crisis stabilization unit.

2. A crisis stabilization unit shall:

a. Be a community-based, residential program that offers an array of services including:

(i) Screening;
 (ii) Assessment;
 (iii) Treatment planning;
 (iv) Individual outpatient therapy;
 (v) Family outpatient therapy;
 (vi) Group outpatient therapy; and
 (vii) Psychiatric services;
 b. Provide services in order to:
 (i) Stabilize a crisis and divert an individual from a higher level of care;
 (ii) Stabilize an individual and provide treatment for acute withdrawal, if applicable; and
 (iii) Re-integrate the individual into the individual's community or other appropriate setting in a timely fashion;
 c. Not be part of a hospital;
 d. Be used when an individual:
 (i) Is experiencing a behavioral health emergency that cannot be safely accommodated within the individual's community; and
 (ii) Needs overnight care that is not hospitalization;
 e. Not contain more than sixteen (16) beds; and
 f. Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.
 3. Residential crisis stabilization shall not include:
 a. Room and board;
 b. Educational services;
 c. Vocational services;
 d. Job training services;
 e. Habilitation services;
 f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;
 g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;
 h. Recreational activities;
 i. Social activities; or
 j. Services required to be covered elsewhere in the state plan.
 4. To provide residential crisis stabilization services, an FQHC, an FQHC look-alike, or a PCC shall have:
 a. The capacity to employ staff authorized to provide residential crisis stabilization in accordance with subsection (3)(r) of this section and to coordinate the provision of services among team members;
 b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;
 c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;
 d. Demonstrated experience in serving individuals with behavioral health disorders;
 e. The administrative capacity to ensure the quality of services;
 f. A financial management system that provides documentation of services and costs;
 g. The capacity to document and maintain individual case records; and
 h. Knowledge of substance use disorders.
 (s)1. Residential services for substance use disorders shall:
 a. Be provided in twenty-four (24) hour per day units;
 b. Be short or long term to provide intensive treatment and skills building in a structured and supportive environment;
 c. Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;
 d. Be provided in a twenty-four (24) hour a day, live-in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring mental health and substance use disorders;
 e. Assist a recipient in making necessary changes in the recipient's life to enable the recipient to live drug- or alcohol-free;
 f. Last less than thirty (30) days;
 g. Be provided under the medical direction of a physician;
 h. Provide continuous nursing services;
 i. Be based on individual need and may include:
 (i) Screening;

(ii) Assessment;
 (iii) Service planning;
 (iv) Individual outpatient therapy;
 (v) Group outpatient therapy; or
 (vi) Family outpatient therapy; and
 j. Be provided in accordance with 908 KAR 1:370.
 2. A residential service for substance use disorder building shall have more than eight (8) but less than seventeen (17) beds.
 3. A short-term length-of-stay for residential services for substance use disorders shall:
 a. Be between fourteen (14) and twenty-eight (28) days in duration;
 b. Include planned clinical program activities constituting at least fifteen (15) hours per week of structured professionally-directed treatment activities to:
 (i) Stabilize and maintain a person's substance use disorder; and
 (ii) Help the recipient develop and apply recovery skills; and
 c. May include the services listed in subparagraph 1.i. of this paragraph.
 4. A long-term length-of-stay for residential services for substance use disorders shall:
 a. Be between twenty-eight (28) days and ninety (90) days in duration;
 b. Include planned clinical program activities constituting at least forty (40) hours per week of structured professionally-directed treatment activities to:
 (i) Stabilize and maintain a person's substance use disorder; and
 (ii) Help the recipient develop and apply recovery skills; and
 c. May include the services listed in subparagraph 1.i. of this paragraph.
 5. Residential services for a substance use disorder shall not include:
 a. Room and board;
 b. Educational services;
 c. Vocational services;
 d. Job training services;
 e. Habilitation services;
 f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;
 g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;
 h. Recreational activities;
 i. Social activities; or
 j. Services required to be covered elsewhere in the state plan.
 6. The physical structure in which residential services for a substance use disorder are provided shall not:
 a. Contain more than sixteen (16) beds; and
 b. Be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.
 7. To provide residential services for a substance use disorder, an FQHC, an FQHC look-alike, or a PCC shall:
 a. Have the capacity to employ staff authorized to provide residential services for substance use disorders in accordance with subsection (3)(s) of this section and to coordinate the provision of services among team members;
 b. Have the capacity to provide the full range of residential services for a substance use disorder as stated in this paragraph;
 c. Have demonstrated experience in serving individuals with behavioral health disorders;
 d. Have the administrative capacity to ensure quality of services;
 e. Have a financial management system that provides documentation of services and costs;
 f. Have the capacity to document and maintain individual case records; and
 g. Be licensed as a nonmedical and nonhospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370.
 (t)1. Therapeutic rehabilitation program services shall:
 a. Occur at the provider's site or in the community;
 b. Be provided to an adult with a severe mental illness or to a

child (under the age of twenty-one (21) years) to enhance skills and offer experiential learning opportunities that are aligned with treatment goals and recovery principles:

c. Not be a residential program; and
d. Be a day program based on the Fountain House clubhouse model of psychosocial rehabilitation for individuals with a serious mental illness.

2. To provide therapeutic rehabilitation program services, an FQHC, an FQHC look-alike, or a PCC shall:

a. Have the capacity to employ staff authorized to provide therapeutic rehabilitation program services in accordance with subsection (3)(t) of this section and to coordinate the provision of services among team members;

b. Have the capacity to provide the full range of therapeutic rehabilitation program services as stated in this paragraph;

c. Have demonstrated experience in serving individuals with mental health disorders;

d. Have the administrative capacity to ensure quality of services;

e. Have a financial management system that provides documentation of services and costs; and

f. Have the capacity to document and maintain individual case records.

(u)1. Parent or family peer support services shall:

a. Be emotional support that is provided by a parent or family member of a child who is experiencing a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a parent or family member with a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:230;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide parent or family peer support services, a provider shall:

a. Have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ family peer support specialists who are qualified to provide family peer support services in accordance with 908 KAR 2:230;

c. Use a qualified mental health professional to supervise family peer support specialists;

d. Have the capacity to employ staff authorized to provide parent or family peer support in accordance with subsection (3)(u) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of parent or family peer support as stated in subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(5)(a) The following requirements shall apply to any provider of a service to a recipient for a substance use disorder or co-occurring mental health disorder and substance use disorder:

1. The licensing requirements established in 908 KAR 1:370;

2. The physical plant requirements established in 908 KAR

1:370;

3. The organization and administration requirements established in 908 KAR 1:370;

4. The personnel policy requirements established in 908 KAR 1:370;

5. The quality assurance requirements established in 908 KAR 1:370;

6. The clinical staff requirements established in 908 KAR 1:370;

7. The program operational requirements established in 908 KAR 1:370; and

8. The outpatient program requirements established in 908 KAR 1:370.

(b) The detoxification program requirements established in 908 KAR 1:370 shall apply to a provider of a detoxification service.

(6) The extent and type of assessment performed at the time of a screening shall depend upon the problem of the individual seeking or being referred for services.

(7) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(8)(a) Direct contact between a provider or practitioner and a recipient shall be required for each service except for a collateral service for a child under the age of twenty-one (21) years if the collateral service is in the child's plan of care.

(b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(9) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter.

(10) A service shall be:

(a) Stated in a recipient's treatment plan;

(b) Provided in accordance with a recipient's treatment plan;

(c) Provided on a regularly scheduled basis except for a screening or assessment; and

(d) Made available on a nonscheduled basis if necessary during a crisis or time of increased stress for the recipient.

(11) The following services or activities shall not be covered under this administrative regulation:

(a) A behavioral health service provided to:

1. A resident of:

a. A nursing facility; or

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

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;

(c) A consultation or educational service provided to a recipient or to others;

(d) Collateral outpatient therapy for an individual aged twenty-one (21) years or older;

(e) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;

(f) Travel time;

(g) A field trip;

(h) A recreational activity;

(i) A social activity; or

(j) A physical exercise activity group.

(12)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as specified in Section 2(2)(k).

(b) A third party contract shall not be covered under this administrative regulation.

Section 6. Drugs for Specified Immunizations. The Cabinet for

Health and Family Services shall provide free, upon request, drugs necessary for the following immunizations:

- (1) Diphtheria and tetanus toxoids and pertussis vaccine (DPT);
- (2) Measles, mumps, and rubella virus vaccine live (MMR);
- (3) Poliovirus vaccine, live, oral, any type (OPV); or
- (4) Hemophilus B conjugate vaccine (HBCV).

Section 7.[5-] Coverage Limits. (1)(a) Except as established in subsection (2) of this section, pharmacy service coverage shall be limited to drugs covered pursuant to 907 KAR 1:019.

(b) A drug or biological not covered through the department's pharmacy program shall be covered if necessary for treatment of an emergency condition.

(2) Laboratory service coverage shall be limited to:

(a) Services provided directly by a PCC, an FQHC, or an FQHC look-alike; or

(b) If purchased, other laboratory services covered pursuant to 907 KAR 1:028.

(3) Dental service coverage shall be limited to dental service coverage pursuant to 907 KAR 1:026.

(4) Vision service coverage shall be limited to vision service coverage pursuant to 907 KAR 1:038.

(5) Audiology service coverage shall be limited to hearing service coverage pursuant to 907 KAR 1:038.

(6) An abortion or sterilization service shall be:

(a) Allowed in accordance with:

1. 42 C.F.R.441, Subpart E or Subpart F; and
2. KRS 205.010(3), 205.510(5), and 212.275(3); and

(b) Covered within the scope and limitations of federal law, federal regulations, and state law.

(7) Durable medical good and prosthetic coverage shall be limited to durable medical good or prosthetic coverage pursuant to 907 KAR 1:479 or 907 KAR 1:030.

(8) A holding or observation accommodation shall be covered:

(a) For no more than twenty-four (24) hours; and

(b) If:

1. The recipient's medical record:

a. Documents the appropriateness of the holding or observation accommodation; and

b. Contains a statement of conditions observed and treatment rendered during the holding time;

2. A physician:

a. Determines that the holding or observation accommodation is necessary; and

b. Is on call at all times when a recipient is held beyond the regularly scheduled hours of the center; and

3. A licensed nurse is on duty during the time the recipient patient remains beyond regularly-scheduled hours.

(9) A radiology procedure shall be covered if provided by a licensed practitioner of the healing arts or by an individual holding a valid certificate to operate sources of radiation.

Section 8.[6-] Noncovered Services. (1) The following services shall not be covered as PCC,[or] FQHC, or FQHC look-alike services:

(a)[(1)] Services provided in a hospital as defined in 42 U.S.C. 1395x(e);

(b)[(2)] Institutional services;

(c)[(3)] Housekeeping, babysitting, or other similar homemaker services;[or]

(d)[(4)] Services which are not provided in accordance with restrictions imposed by law or administrative regulation;

(e) A behavioral health service provided to:

1. A resident of:

a. A nursing facility; or

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

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(f) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;

(g) A consultation or educational service provided to a recipient or to others;

(h) Collateral outpatient therapy for an individual aged twenty-one (21) years or older;

(i) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;

(j) Travel time;

(k) A field trip;

(l) A recreational activity;

(m) A social activity; or

(n) A physical exercise activity group.

(2)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as specified in Section 2(2)(k).

(b) A third party contract shall not be covered under this administrative regulation.

Section 9. Medical Necessity Requirement. To be covered pursuant to this administrative regulation, a service shall be:

(1) Medically necessary for the recipient; and

(2) Provided to a recipient.

Section 10. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a service from an independent mental health service provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a primary care center.

Section 11. Protection, Security and Records Maintenance Requirements for All Services. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3)(a) A provider shall comply with 45 C.F.R. Part 164.

(b) All information contained in a health record shall:

1. Be treated as confidential;

2. Not be disclosed to an unauthorized individual; and

3. If requested, be disclosed to an authorized representative of:

a. The department; or

b. Federal government.

(c)1. Upon request, a provider shall provide to an authorized representative of the department or federal government information requested to substantiate:

a. Staff notes detailing a service that was rendered;

b. The professional who rendered a service;

c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department.

2. Failure to provide information referenced in subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 12. Documentation and Records Maintenance Requirements for Behavioral Health Services. (1) The requirements in this section shall apply to health records associated with behavioral health services.

(2) A health record shall:

(a) Include:

1. An identification and intake record including:

a. Name;

b. Social Security number;

c. Date of intake;

d. Home (legal) address;

e. Health insurance information;

f. Referral source and address of referral source;

g. Primary care physician and address;

h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider; and

k. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

(i) This administrative regulation;

(ii) The provider's licensure board;

(iii) State law; or

(iv) Federal law;

2. Documentation of the:

a. Screening;

b. Assessment;

c. Disposition; and

d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;

3. A complete history including mental status and previous treatment;

4. An identification sheet;

5. A consent for treatment sheet that is accurately signed and dated; and

6. The individual's stated purpose for seeking services; and

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the Cabinet for Health and Family Services upon request;

3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;

4. Readily accessible; and

5. Adequate for the purpose establishing the current treatment modality and progress of the recipient.

(3) Documentation of a screening shall include:

(a) Information relative to the individual's stated request for services; and

(b) Other stated personal or health concerns if other concerns are stated.

(4)(a) A provider's notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit;

2. Describe the:

a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

b. Therapist's intervention;

c. Changes in the treatment plan if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional providing the service.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the

practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(5) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) An appropriate diagnosis;

(b) A referral for further consultation and disposition, if applicable; and

(c)1. Termination of services and referral to an outside source for further services; or

2. Termination of services without a referral to further services.

(6)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.

(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.

(7)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Be dated;

3. Be titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(8) A termination summary shall:

(a) Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

(b) Contain a summary of the significant findings and events during the course of treatment including the:

1. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

2. Final diagnosis of clinical impression; and

3. Individual's condition upon termination and disposition.

(c) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(9) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(10) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient.

(11)(a) If a provider's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records of the provider shall:

1. Remain the property of the provider; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A provider shall have a written plan addressing how to maintain health records in the event of the provider's death.

Section 13. Medicaid Program Participation Requirements.

(1)(a) A participating FQHC, FQHC look-alike, or PCC shall be currently:

1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

2. Except as established in paragraph (c) of this subsection, participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671.

(b) A satellite facility of an FQHC, an FQHC look-alike, or a PCC shall:

1. Be currently listed on the parent facility's license in accordance with 902 KAR 20:058;

2. Comply with the requirements regarding extensions established in 902 KAR 20:058; and

3. Comply with 907 KAR 1:671.

(c) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) To be initially enrolled with the department, an FQHC or FQHC look-alike shall:

1. Enroll in accordance with 907 KAR 1:672; and

2. Submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC or FQHC look-alike.

(b) To remain enrolled and participating in the Kentucky Medicaid Program, an FQHC or FQHC look-alike shall:

1. Comply with the enrollment requirements established in 907 KAR 1:672;

2. Comply with the participation requirements established in 907 KAR 1:671; and

3. Annually submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC or FQHC look-alike to the department.

(c) The requirements established in paragraphs (a) and (b) of this subsection shall apply to a satellite facility of an FQHC or FQHC look-alike.

(3) An FQHC, an FQHC look-alike, or a PCC that operates multiple satellite facilities shall:

(a) List each satellite facility on the parent facility's license in accordance with 902 KAR 20:058; and

(b) Consolidate claims and cost report data of its satellite facilities with the parent facility.

(4) An FQHC, an FQHC look-alike, or a PCC that has been terminated from federal participation shall be terminated from Kentucky Medicaid Program participation.

(5)(a) A participating FQHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC.

(b) A participating FQHC look-alike and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC look-alike.

(c) A participating PCC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of a PCC.

(6) An FQHC, an FQHC look-alike, or a PCC performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

(7)(a) If an FQHC, an FQHC look-alike, or a PCC receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(8) An FQHC, an FQHC look-alike, or a PCC shall:

(a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability; and

(b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the act.

Section 14. Third Party Liability. A provider shall comply with KRS 205.622.

Section 15. 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 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, or 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 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 16. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 17. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 18. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program federally-qualified health center (FQHC) services, FQHC look-alike services, and primary care center (PCC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program FQHC services, FQHC look-alike services, and PCC 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 coverage provisions and requirements regarding Medicaid

Program FQHC services, FQHC look-alike services, and PCC 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 authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program FQHC services, FQHC look-alike services, and PCC 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 primary amendment authorizes FQHCs, FQHC look-alikes, and PCCs to provide substance use disorder services and expands these providers scope of behavioral health services as well as expands the types of practitioners/professionals who can provide services in an FQHC, an FQHC look-alike, or a PCC. Additional amendments include inserting various program integrity requirements such as requiring FQHCs, FQHC look-alikes, and PCCs to bill third parties for services if a third party is involved and not duplicate bill for a service provided to the recipient by another provider. Other amendments include establishing that FQHCs, FQHC look-alikes, and PCCs must comply with records maintenance/security requirements and Medicaid provider participation requirements. A new section is added to authorize FQHCs, FQHC look-alikes, and PCCs to utilize electronic signatures. Another section is added to establish that Medicaid Program coverage of FQHC services, FQHC look-alike services, and PCC services under this administrative regulation is contingent upon federal approval and federal funding. Also, there is an amendment which clarifies that the Department for Medicaid Services has the authority to audit any provider claim, medical record, or documentation associated with any claim or medical record. Lastly, a section establishing recipient appeal rights regarding adverse actions is added.

(b) The necessity of the amendment to this administrative regulation: The primary amendment – amendment related to substance use disorder services and behavioral health services – is necessary to comply with a federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." Additionally, the Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange. The Medicaid Program is required to ensure that recipients have access to services. Other amendments are necessary to enhance program integrity requirements, establish that coverage of services is contingent upon federal funding (in order to protect state taxpayer generated funds), and establish appeal rights for Medicaid recipients.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(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 complying

with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Federally-qualified health centers and primary care centers will be affected by this amendment. Additionally, licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide substance use disorder services or the enhanced behavioral health services (established in this amendment) while working for or under contract with an FQHC, FQHC look-alike, or PCC will also be affected by this administrative regulation. Medicaid recipients who qualify for substance use disorder services or the enhanced scope of behavioral health services will also be affected by this amendment.

(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. FQHCs, FQHC look-alikes, and PCCs will need to ensure that they use the practitioners authorized in this administrative regulation to provide the new scope of services (expanded behavioral health services and substance use disorder services) if the given FQHCs, FQHC look-alikes, or PCCs wish to expand their scope of services accordingly.

(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 anticipated as expanding the scope of services is voluntary.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). FQHCs, FQHC look-alikes, and PCCs will benefit by being authorized to provide more services. The expanded types of behavioral health practitioners/professionals will benefit by having more employment opportunities in which to provide services. Medicaid recipients will benefit by having enhanced access to behavioral health services and substance use disorder services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in FQHC, FQHC look-alikes, and PCCs due to the variables involved as DMS cannot estimate how many FQHCs, FQHC look-alikes, or PCCs will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in FQHCs, FQHC look-alikes, or PCCs.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 to implement this administrative regulation.

(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

policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2).

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

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 the amendment to this administrative regulation as will any FQHC, FQHC look-alike, or PCC owned by a government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many FQHCs, FQHC look-alikes, or PCCs that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in FQHC, FQHC look-alikes, and PCCs due to the variables involved as DMS cannot estimate how many FQHCs, FQHC look-alikes, or PCCs will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in FQHCs, FQHC look-alikes, or PCCs.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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

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

STATEMENT OF EMERGENCY 907 KAR 1:082E

This emergency administrative regulation is being promulgated to comply with an Affordable Care Act mandate. The amendment to this administrative regulation is necessary to establish Kentucky Medicaid Program coverage and reimbursement of additional behavioral health services including substance use disorder services. The Department for Medicaid Services (DMS) currently covers substance use related services for pregnant women and children; however, the Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria.) Additionally, DMS is expanding the base of behavioral health providers to ensure that there is an adequate supply of providers to meet Medicaid recipient demand for care – as federally required. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Emergency Amendment)

907 KAR 1:082E. Coverage provisions and requirements regarding rural health clinic services.

RELATES TO: KRS 205.520, 314.011, 319.050, 335.100, 42

C.F.R. 400.203, 42 C.F.R. 405.2401(b), 405.2412-405.2417, 405.2450, 405.2452, 405.2468, 440.20, 42 C.F.R. 491.1-491.11, 42 U.S.C. 1395x(aa) and (hh)

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

EFFECTIVE: December 30, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS[Chapter] 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program coverage provisions and requirements relating to [coverage of] rural health clinic services[for which payment shall be made by the Medicaid Program on behalf of both categorically needy and medically needy].

Section 1. Definitions. (1) "Advanced practice registered nurse[practitioner]" is defined by KRS [Chapter] 314.011(7).

(2) "Certified social worker" means an individual who:

- (a) Meets the requirements established in KRS 335.080; and
- (b) Has at least a master's degree in social work.

(3) "Clinical psychologist" means a doctorate level psychologist who is licensed in accordance with KRS 319.050.

(4) "Club house model of psychosocial rehabilitation" means a form of psychosocial rehabilitation that focuses on self-help, friendship, emotional support, acceptance, and meaningful and gainful employment.

(5) "Community support associate" means an individual who meets the community support associate requirements established in 908 KAR 2:250.

(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.

(8) "Face-to-face" means occurring:

- (a) In person; or
- (b) Via a real-time, electronic communication that involves two (2) way interactive video and audio communication.

(9) "Family peer support specialist" means an individual who meets the requirements for a Kentucky family peer support specialist established in 908 KAR 2:230.

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

(11) "Fountain House" means the professional self-help program located in New York City about which information is available on the Web site of <http://www.fountainhouse.org/>.

(12)[(4)] "Homebound recipient" is defined by 42 C.F.R. 440.20(b)(4)(iv).

(13)[(5)] "Intermittent nursing care" is defined by 42 C.F.R. 405.2401(b).

(14)[(6)] "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(15) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(16) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(17) "Licensed professional counselor associate" is defined by KRS 335.500(3).

(18) "Licensed psychological associate" means an individual who:

- (a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and
- (b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.

(19) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(20) "Licensed psychologist" means an individual who:

- (a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

(21) "Managed care organization" 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.

(22) "Marriage and family therapy associate" is defined by KRS 335.300(3).

(23)[(7)] "Medically necessary" means that a covered benefit or service is necessary in accordance with[the provisions of] 907 KAR 3:130[Section 2].

(24)[(8)] "Nurse-midwife" is defined by 42 C.F.R. 405.2401(b).

(25)[(9)] "Other ambulatory services" is defined by 42 C.F.R. 440.20(c).

(26)[(10)] "Part-time nursing care" is defined by 42 C.F.R. 405.2401(b).

(27) "Peer support specialist" means an individual who meets the peer specialist qualifications established in 908 KAR 2:220.

(28)[(11)] "Physician" is defined by KRS 205.510(11) and 42 C.F.R. 405.2401(b).

(29)[(12)] "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(30) "Qualified mental health professional" is defined by KRS 202A.011(12).

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

(32)[(13)] "Rural health clinic" or "RHC" is defined by 42 C.F.R. 405.2401(b).

(33)[(14)] "State plan" is defined by 42 C.F.R. 400.203.

(34)[(15)] "Visiting nurse services" is defined by 42 C.F.R. 405.2401(b).

(35) "Youth peer support specialist" means an individual who meets the requirements established for a Kentucky youth peer support specialist established in 908 KAR 2:240.

Section 2. Covered Services Other Than Behavioral Health Services. The department shall cover the following medically necessary rural health clinic services furnished by an RHC that has been certified in accordance with 42 C.F.R. 491.1 through 491.11:

(1) Services pursuant to 42 U.S.C. 1395x(aa);

(2) Services provided by a physician if the physician:

(a) Complies with the physician responsibility requirements established by 42 C.F.R. 491.8(b); and

(b)1. Performs the services in an RHC; or

2. Is compensated under an agreement with an RHC for providing services furnished to a Medicaid eligible RHC patient in a location other than the RHC;

(3) Services provided by a physician assistant, advanced practice registered nurse[practitioner], or nurse midwife who is employed by or receives compensation from the RHC if the services:

(a) Are furnished by a member of the RHC's staff who complies with the responsibility requirements established by 42 C.F.R. 491.8(c);

(b) Are furnished under the medical supervision of a physician;

(c) Are furnished in accordance with a medical order for the care and treatment of a patient as prepared by a physician;

(d) Are within the provider's legally-authorized scope of practice; and

(e) Would be covered if furnished by a physician;

(4) Services or supplies furnished as an incident to services provided by a physician, physician assistant, advanced practice registered nurse[practitioner], or nurse midwife if the service or supply meets the criteria established in 42 C.F.R. 405.2413 or 42 C.F.R. 405.2415;

(5) Part-time or intermittent visiting nurse care and related supplies, except for drugs or biologicals, if:

(a) The RHC is located in an area where a determination has been made that there is a shortage of home health agencies pursuant to 42 C.F.R. 405.2417;

(b) The services are provided by a registered nurse, licensed practical nurse, or a licensed vocational nurse who is employed by or compensated for the services by the RHC; and

(c) The services are furnished to a homebound recipient under a written plan of treatment that is:

1. Established and reviewed at least every sixty (60) days by a supervising physician of the RHC; or

2. Established by a physician, physician assistant, advanced practice registered nurse[practitioner], or nurse midwife and reviewed and approved at least every sixty (60) days by a supervising physician of the RHC; or

(6) Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced practice registered nurse practitioner if the services are:

(a) Provided by an individual who is employed by or furnishes services under contract to the RHC; and

(b) Within the provider's legally authorized scope of practice;

(7) Services or supplies incident to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in 42 C.F.R. 405.2452; and

(8) Other ambulatory services as established in the state plan.

Section 3. Behavioral Health Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for:

(a) A mental health disorder;

(b) A substance use disorder; or

(c) Co-occurring mental health and substance use disorders.

(2) The department shall cover, and a rural health clinic may provide, the following services:

(a) Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced practice registered nurse within the provider's legally authorized scope of service; or

(b) Services or supplies incidental to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in Title 42 C.F.R.

(3) In addition to the services referenced in subsection (2) of this section, the following behavioral health services provided by a rural health clinic shall be covered under this administrative regulation in accordance with the corresponding following requirements:

(a) A screening provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(b) An assessment provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the

supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(c) Psychological testing provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner; or

3. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

(d) Crisis intervention provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(e) Service planning provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the

licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(r) Residential crisis stabilization provided by a team of at least two (2) of the following:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(s) Residential services for a substance use disorder provided by a team of at least two (2) of the following:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(t) Therapeutic rehabilitation program services provided by a team of at least two (2) of the following individuals:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional; or

(u) Parent or family peer support provided by:

1. A peer support specialist working under the supervision of a mental health professional;

2. A family peer support specialist working under the supervision of a mental health professional; or

3. A youth peer support specialist working under the supervision of a mental health professional.

(4)(a) A screening shall:

1. Be the determination of the likelihood that an individual has a mental health disorder, a substance use disorder, or co-occurring disorders;

2. Not establish the presence or specific type of disorder; and

3. Establish the need for an in-depth assessment.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the provider to:

a. Establish the presence or absence of a mental health disorder or substance use disorder;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinic disorder or service need;

3. Include working with the individual to develop a treatment and service plan; and

4. Not include a psychological or psychiatric evaluation or assessment.

(c) Psychological testing shall include:

1. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and

2. Interpretation and a written report of testing results.

(d) Crisis intervention:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:

a. The recipient; or

b. Another individual;

2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for an individual with a behavioral health disorder;

3. Shall be provided:

a. In an office, home, or community setting where the individual is experiencing the crisis;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one-on-one encounter between the provider and the recipient;

4. May include verbal de-escalation, risk assessment, or cognitive therapy; and

5. Shall be followed by a referral to non-crisis services if applicable.

(e)1. Service planning shall consist of assisting a recipient in creating an individualized plan for services needed to maintain functional stability or return to stability as soon as possible in order to avoid out-of-home care.

2. A service plan:

a. Shall be directed by the recipient; and

b. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

(f) Individual outpatient therapy shall:

1. Be provided to promote the:

a. Health and wellbeing of the individual; or

b. Recovery from a substance related disorder;

2. Consist of:

a. A face-to-face, one-on-one encounter between the provider and recipient; and

b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

a. Reducing adverse symptoms;

b. Reducing or eliminating the presenting problem of the recipient; and

c. Improving functioning; and

4. Not exceed three (3) hours per day.

(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals, including multiple members from one (1) family, who participate in the session.

(h)1. Group outpatient therapy shall:

a. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Recovery from a substance related disorder;

b. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

c. Be provided to a recipient in a group setting:

(i) Of nonrelated individuals; and

(ii) Not to exceed eight (8) individuals in size;

d. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

e. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and

f. Not exceed three (3) hours per day.

2. The group shall have a:

a. Deliberate focus; and

b. Defined course of treatment.

3. The subject of a group receiving group outpatient therapy shall be related to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.

(i)1. Collateral outpatient therapy shall:

a. Consist of a face-to-face behavioral health consultation:

(i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or

supervision of the recipient; and

(ii) That is provided in accordance with the recipient's treatment plan; and

b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age.

2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.

(i) Screening, brief intervention, and referral to treatment for a substance use disorder shall:

1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and

2. Consist of:

a. Using a standardized screening tool to assess an individual for risky substance use behavior;

b. Engaging a recipient who demonstrates risky substance use behavior in a short conversation and providing feedback and advice; and

c. Referring a recipient to:

(i) Therapy; or

(ii) Other additional services to address substance use if the recipient is determined to need other additional services.

(k) Medication assisted treatment for a substance use disorder:

1. Shall include:

a. Any opioid addiction treatment that includes a United States Food and Drug Administration-approved medication for the detoxification or maintenance treatment of opioid addiction along with counseling or other supports;

b. Comprehensive maintenance;

c. Medical maintenance;

d. Interim maintenance;

e. Detoxification; or

f. Medically supervised withdrawal;

2. May be provided in:

a. An opioid treatment program;

b. A medication unit affiliated with an opioid treatment program;

c. A physician's office; or

d. Other community setting; and

3. Shall increase the likelihood for cessation of illicit opioid use or prescription opioid abuse.

(l)1. Day treatment shall be a nonresidential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:

a. An emotional disability or neurobiological or substance use disorder; and

b. A high risk of out-of-home placement due to a behavioral health issue.

2. Day treatment services shall:

a. Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorders);

b. Have unified policies and procedures that:

(i) Address the program philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning; and

(ii) Have been approved by the recipient's local education authority and the day treatment provider;

c. Include:

(i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

(ii) Behavior management and social skill training;

(iii) Independent living skills that correlate to the age and development stage of the recipient; or

(iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and

d. Be provided:

(i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29

U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act):

- (ii) On school days and during scheduled breaks;
- (iii) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;
- (iv) Under the supervision of a licensed or certified behavioral health practitioner or a behavioral health practitioner working under clinical supervision; and
- (v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.
- 3. To provide day treatment services, an RHC shall have:
 - a. The capacity to employ staff authorized to provide day treatment services in accordance with subsection (3)(l) of this section and to coordinate the provision of services among team members;
 - b. The capacity to provide the full range of residential crisis stabilization services as stated in subparagraph 1 of this paragraph;
 - c. Demonstrated experience in serving individuals with behavioral health disorders;
 - d. The administrative capacity to ensure quality of services;
 - e. A financial management system that provides documentation of services and costs;
 - f. The capacity to document and maintain individual case records; and
 - g. Knowledge of substance use disorders.
- 4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.
- (m)1. Comprehensive community support services shall:
 - a. Be activities necessary to allow an individual to live with maximum independence in community-integrated housing;
 - b. Be intended to ensure successful community living through the utilization of skills training, cueing, or supervision as identified in the recipient's treatment plan;
 - c. Include:
 - (i) Reminding a recipient to take medications and monitoring symptoms and side effects of medications; or
 - (ii) Teaching parenting skills, teaching community resource access and utilization, teaching emotional regulation skills, teaching crisis coping skills, teaching how to shop, teaching about transportation, teaching financial management, or developing and enhancing interpersonal skills; and
 - d. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.
- 2. To provide comprehensive community support services, an RHC shall have:
 - a. The capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (3)(m) of this section and to coordinate the provision of services among team members;
 - b. The capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;
 - c. Demonstrated experience in serving individuals with behavioral health disorders;
 - d. The administrative capacity to ensure quality of services;
 - e. A financial management system that provides documentation of services and costs; and
 - f. The capacity to document and maintain individual case records.
- (n)1. Peer support services shall:
 - a. Be social and emotional support that is provided by an individual who is experiencing a mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders to a recipient by sharing a similar mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;
 - b. Be an evidence-based practice;
 - c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;
 - d. Be provided by a self-identified consumer or parent or family member of a child consumer of mental health disorder services,

substance use disorder services, or co-occurring mental health and substance use disorders services who has been trained and certified in accordance with 908 KAR 2:220;

- e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and
- f. Be identified in each recipient's treatment plan.
- 2. To provide peer support services, an RHC shall:
 - a. Have demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served including the age range of the population being served;
 - b. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220;
 - c. Use a qualified mental health professional to supervise peer support specialists;
 - d. Have the capacity to employ staff authorized to provide peer support in accordance with subsection (3)(n) of this section and to coordinate the provision of services among team members;
 - e. Have the capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;
 - f. Have demonstrated experience in serving individuals with behavioral health disorders;
 - g. Have the administrative capacity to ensure quality of services;
 - h. Have a financial management system that provides documentation of services and costs; and
 - i. Have the capacity to document and maintain individual case records.
- (o)1. Mobile crisis services shall:
 - a. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the year; and
 - b. Be a crisis response in a home or community setting to provide an immediate evaluation, triage, and access to acute substance use disorder services including treatment and supports to:
 - (i) Reduce symptoms or harm; or
 - (ii) Safely transition an individual in an acute crisis to appropriate crisis stabilization and detoxification supports or services.
- 2. To provide mobile crisis services, an RHC shall have:
 - a. The capacity to employ staff authorized to provide mobile crisis services in accordance with subsection (3)(o) of this section and to coordinate the provision of services among team members;
 - b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;
 - c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;
 - d. Demonstrated experience in serving individuals with behavioral health disorders;
 - e. The administrative capacity to ensure quality of services;
 - f. A financial management system that provides documentation of services and costs;
 - g. The capacity to document and maintain individual case records; and
 - h. Knowledge of substance use disorders.
- (p)1. Assertive community treatment shall:
 - a. Be an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for individuals with a serious mental illness;
 - b. Use a multidisciplinary team of at least two (2) of the following professionals:
 - (i) A psychiatrist;
 - (ii) A nurse;
 - (iii) A case manager; or
 - (iv) A therapist; and
 - c. Include:
 - (i) Assessment;
 - (ii) Treatment planning;

- (iii) Case management;
- (iv) Psychiatric services;
- (v) Medication management administration;
- (vi) Individual outpatient therapy;
- (vii) Family outpatient therapy;
- (viii) Group outpatient therapy;
- (ix) Mobile crisis intervention;
- (x) Mental health consultation; or
- (xi) Family support and basic living skills.

2. To provide assertive community treatment services, an RHC shall:

- a. Employ one (1) or more teams:
 - (i) Led by a qualified mental health professional; and
 - (ii) Comprised of at least four (4) full-time equivalents including a prescriber, a nurse, a qualified mental health professional, a case manager, or a co-occurring disorders specialist;
 - b. Have adequate staffing to ensure that no caseload size exceeds ten (10) participants per team member;
 - c. Have the capacity to employ staff authorized to provide assertive community treatment services in accordance with subsection (3)(p) of this section and to coordinate the provision of services among team members;
 - d. The capacity to provide the full range of assertive community treatment services as stated in this paragraph;
 - e. Demonstrated experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community;
 - f. The administrative capacity to ensure quality of services;
 - g. A financial management system that provides documentation of services and costs; and
 - h. The capacity to document and maintain individual case records.
- (q)1. Intensive outpatient program services shall:
- a. Be an alternative to inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;
 - b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy; and
 - c. Be provided at least three (3) hours per day at least three (3) days per week; and
 - d. Include:
 - (i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless contraindicated;
 - (ii) Crisis intervention; or
 - (iii) Psycho-education.

2. During psycho-education, the recipient or family member shall be:

- a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and
- b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

3. An intensive outpatient program treatment plan shall:

- a. Be individualized; and
- b. Focus on stabilization and transition to a lesser level of care.

4. To provide intensive outpatient program services, an RHC shall have:

- a. Access to a board-certified or board-eligible psychiatrist for consultation;
- b. Access to a psychiatrist, other physician, or advanced practiced registered nurse for medication management;
- c. Adequate staffing to ensure a minimum recipient-to-staff ratio of four (4) recipients to one (1) staff;
- d. The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;
- e. The capacity to employ staff authorized to provide intensive outpatient program services in accordance with subsection (3)(q) of this section and to coordinate the provision of services among team members;
- f. The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;
- g. Demonstrated experience in serving individuals with

behavioral health disorders:

- h. The administrative capacity to ensure quality of services;
- i. A financial management system that provides documentation of services and costs; and
- j. The capacity to document and maintain individual case records.

(r)1. Residential crisis stabilization services shall be provided in a crisis stabilization unit.

2. A crisis stabilization unit shall:

a. Be a community-based, residential program that offers an array of services including:

- (i) Screening;
- (ii) Assessment;
- (iii) Treatment planning;
- (iv) Individual outpatient therapy;
- (v) Family outpatient therapy;
- (vi) Group outpatient therapy; and
- (vii) Psychiatric services;

b. Provide services in order to:

(i) Stabilize a crisis and divert an individual from a higher level of care;

(ii) Stabilize an individual and provide treatment for acute withdrawal, if applicable; and

(iii) Re-integrate the individual into the individual's community or other appropriate setting in a timely fashion;

c. Not be part of a hospital;

d. Be used when an individual:

(i) Is experiencing a behavioral health emergency that cannot be safely accommodated within the individual's community; and

(ii) Needs overnight care that is not hospitalization;

e. Not contain more than sixteen (16) beds; and

f. Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

3. Residential crisis stabilization shall not include:

- a. Room and board;
- b. Educational services;
- c. Vocational services;
- d. Job training services;
- e. Habilitation services;
- f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

h. Recreational activities;

i. Social activities; or

j. Services required to be covered elsewhere in the state plan.

4. To provide residential crisis stabilization services, an RHC shall have:

a. The capacity to employ staff authorized to provide residential crisis stabilization services in accordance with subsection (3)(r) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;

c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;

d. Demonstrated experience in serving individuals with behavioral health disorders;

e. The administrative capacity to ensure the quality of services;

f. A financial management system that provides documentation of services and costs;

g. The capacity to document and maintain individual case records; and

h. Knowledge of substance use disorders.

(s)1. Residential services for substance use disorders shall:

a. Be provided in twenty-four (24) hour per day units;

b. Be short or long term to provide intensive treatment and skills building in a structured and supportive environment;

c. Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;

d. Be provided in a twenty-four (24) hour a day, live-in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring mental health and substance use disorders;

e. Assist a recipient in making necessary changes in the recipient's life to enable the recipient to live drug- or alcohol-free;

f. Last less than thirty (30) days;

g. Be provided under the medical direction of a physician;

h. Provide continuous nursing services;

i. Be based on individual need and may include:

(i) Screening;

(ii) Assessment;

(iii) Service planning;

(iv) Individual outpatient therapy;

(v) Group outpatient therapy; or

(vi) Family outpatient therapy; and

j. Be provided in accordance with 908 KAR 1:370.

2. A residential service for substance use disorder building shall have more than eight (8) but less than seventeen (17) beds.

3. A short-term length-of-stay for residential services for a substance use disorder shall:

a. Be between fourteen (14) and twenty-eight (28) days in duration;

b. Include planned clinical program activities constituting at least fifteen (15) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize and maintain a person's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.i. of this paragraph.

4. A long-term length-of-stay for residential services for a substance use disorder shall:

a. Be between twenty-eight (28) days and ninety (90) days in duration;

b. Include planned clinical program activities constituting at least forty (40) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize and maintain a person's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.i. of this paragraph.

5. Residential services for a substance use disorder shall not include:

a. Room and board;

b. Educational services;

c. Vocational services;

d. Job training services;

e. Habilitation services;

f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

h. Recreational activities;

i. Social activities; or

j. Services required to be covered elsewhere in the state plan.

6. The physical structure in which residential services for a substance use disorder are provided shall not:

a. Contain more than sixteen (16) beds; and

b. Be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

7. To provide residential services for a substance use disorder, an RHC shall:

a. Have the capacity to employ staff authorized to provide residential services for a substance use disorder in accordance with subsection (3)(s) of this section and to coordinate the provision of services among team members;

b. Have the capacity to provide the full range of residential services for a substance use disorder as stated in this paragraph;

c. Have demonstrated experience in serving individuals with behavioral health disorders;

d. Have the administrative capacity to ensure quality of

services;

e. Have a financial management system that provides documentation of services and costs;

f. Have the capacity to document and maintain individual case records; and

g. Be licensed as a nonmedical and nonhospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370.

(t)1. Therapeutic rehabilitation program services shall:

a. Occur at the provider's site or in the community;

b. Be provided to an adult with a severe mental illness or to a child (under the age of twenty-one (21) years) to enhance skills and offer experiential learning opportunities that are aligned with treatment goals and recovery principles;

c. Not be a residential program; and

d. Be a day program based on the Fountain House clubhouse model of psychosocial rehabilitation for individuals with a serious mental illness.

2. To provide therapeutic rehabilitation program services, an RHC shall:

a. Have the capacity to employ staff authorized to provide therapeutic rehabilitation program services in accordance with subsection (3)(t) of this section and to coordinate the provision of services among team members;

b. Have the capacity to provide the full range of therapeutic rehabilitation program services as stated in this paragraph;

c. Have demonstrated experience in serving individuals with mental health disorders;

d. Have the administrative capacity to ensure quality of services;

e. Have a financial management system that provides documentation of services and costs; and

f. Have the capacity to document and maintain individual case records.

(u)1. Parent or family peer support services shall:

a. Be emotional support that is provided by a parent or family member of a child who is experiencing a mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders to a parent or family member with a child sharing a similar mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health and substance use disorders services who has been trained and certified in accordance with 908 KAR 2:230;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide parent or family peer support services, a provider shall:

a. Have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ family peer support specialists who are qualified to provide family peer support services in accordance with 908 KAR 2:230;

c. Use a qualified mental health professional to supervise family peer support specialists;

d. Have the capacity to employ staff authorized to provide parent or family peer support in accordance with subsection (2)(u) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with

behavioral health disorders:

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(5)(a) The following requirements shall apply to any provider of a service to a recipient for a substance use disorder or co-occurring mental health and substance use disorders:

1. The licensing requirements established in 908 KAR 1:370;

2. The physical plant requirements established in 908 KAR 1:370;

3. The organization and administration requirements established in 908 KAR 1:370;

4. The personnel policy requirements established in 908 KAR 1:370;

5. The quality assurance requirements established in 908 KAR 1:370;

6. The clinical staff requirements established in 908 KAR 1:370;

7. The program operational requirements established in 908 KAR 1:370; and

8. The outpatient program requirements established in 908 KAR 1:370.

(b) The detoxification program requirements established in 908 KAR 1:370 shall apply to a provider of a detoxification service.

(6) The extent and type of assessment performed at the time of a screening shall depend upon the problem of the individual seeking or being referred for services.

(7) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(8)(a) Direct contact between a provider or practitioner and a recipient shall be required for each service except for a collateral service for a child under the age of twenty-one (21) years if the collateral service is in the child's plan of care.

(b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(9) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter.

(10) A service shall be:

(a) Stated in a recipient's treatment plan;

(b) Provided in accordance with a recipient's treatment plan;

(c) Provided on a regularly scheduled basis except for a screening or assessment; and

(d) Made available on a nonscheduled basis if necessary during a crisis or time of increased stress for the recipient.

(11) The following services or activities shall not be covered under this administrative regulation:

(a) A behavioral health service provided to:

1. A resident of:

a. A nursing facility; or

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

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;

(c) A consultation or educational service provided to a recipient or to others;

(d) Collateral outpatient therapy for an individual aged twenty-one (21) years or older;

(e) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;

(f) Travel time;

(g) A field trip;

(h) A recreational activity;

(i) A social activity; or

(j) A physical exercise activity group.

(12)(a) A consultation by one (1) provider or professional with another shall not be covered except as specified in Section 3(4)(i) of this administrative regulation.

(b) A third party contract shall not be covered under this administrative regulation.

Section 5. Provision of Services. An RHC shall comply with the service provision requirements established by 42 C.F.R. 491.9.

Section 6.[4-] Immunizations. An RHC shall provide, upon request from a recipient, the following covered immunizations:

(1) Diphtheria and tetanus toxoids and pertussis vaccine (DPT);

(2) Measles, mumps, and rubella virus vaccine live (MMR);

(3) Poliovirus vaccine, live, oral (any type(s)) (OPV); or

(4) Hemophilus B conjugate vaccine (HBCV).

Section 7. Medical Necessity Requirement. To be covered pursuant to this administrative regulation, a service shall be:

(1) Medically necessary for the recipient; and

(2) Provided to a recipient.

Section 8. Noncovered Services. (1) The following services shall not be covered as rural health clinic services:

(a) Services provided in a hospital as defined in 42 U.S.C. 1395x(e);

(b) Institutional services;

(c) Housekeeping, babysitting, or other similar homemaker services;

(d) Services which are not provided in accordance with restrictions imposed by law or administrative regulation;

(e) A behavioral health service provided to:

1. A resident of:

a. A nursing facility; or

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

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(f) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;

(g) A consultation or educational service provided to a recipient or to others;

(h) Collateral outpatient therapy for an individual aged twenty-one (21) years or older;

(i) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;

(j) Travel time;

(k) A field trip;

(l) A recreational activity;

(m) A social activity; or

(n) A physical exercise activity group.

(2)(a) A consultation by one (1) provider or professional with another shall not be covered except as specified in Section 2(2)(k) of this administrative regulation.

(b) A third party contract shall not be covered under this administrative regulation.

Section 9. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a service from an independent behavioral health service provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a rural health clinic.

Section 10. Protection, Security and Records Maintenance Requirements for All Services. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3)(a) A provider shall comply with 45 C.F.R. Part 164.

(b) All information contained in a health record shall:

1. Be treated as confidential;
2. Not be disclosed to an unauthorized individual; and
3. If requested, be disclosed to an authorized representative of:
 - a. The department; or
 - b. Federal government.

(c)1. Upon request, a provider shall provide to an authorized representative of the department or federal government information requested to substantiate:

- a. Staff notes detailing a service that was rendered;
- b. The professional who rendered a service; and
- c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department.

2. Failure to provide information referenced in subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 11. Documentation and Records Maintenance Requirements for Behavioral Health Services. (1) The requirements in this section shall apply to health records associated with behavioral health services.

(2) A health record shall:

(a) Include:

1. An identification and intake record including:

- a. Name;
- b. Social Security number;
- c. Date of intake;
- d. Home (legal) address;
- e. Health insurance information;
- f. Referral source and address of referral source;
- g. Primary care physician and address;
- h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider; and

k. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

- (i) This administrative regulation;
- (ii) The provider's licensure board;
- (iii) State law; or
- (iv) Federal law;

2. Documentation of the:

- a. Screening;
- b. Assessment;

c. Disposition; and

d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;

3. A complete history including mental status and previous treatment;

4. An identification sheet;

5. A consent for treatment sheet that is accurately signed and dated; and

6. The individual's stated purpose for seeking services; and

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the Cabinet for Health and Family Services upon request;

3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;

4. Readily accessible; and

5. Adequate for the purpose establishing the current treatment modality and progress of the recipient.

(3) Documentation of a screening shall include:

(a) Information relative to the individual's stated request for services; and

(b) Other stated personal or health concerns if other concerns are stated.

(4)(a) A provider's notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit; and

2. Describe the:

a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

b. Therapist's intervention;

c. Changes in the treatment plan if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional providing the service.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(5) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) An appropriate diagnosis;

(b) A referral for further consultation and disposition, if applicable; and

(c)1. Termination of services and referral to an outside source for further services; or

2. Termination of services without a referral to further services.

(6)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.

(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.

(7)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Dated;

3. Titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(8)(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

2. Contain a summary of the significant findings and events during the course of treatment including the:

a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

b. Final diagnosis of clinical impression; and

c. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(9) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(10) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient.

(11)(a) If a provider's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records of the provider shall:

1. Remain the property of the provider; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A provider shall have a written plan addressing how to maintain health records in the event of the provider's death.

Section 12. Medicaid Program Participation Requirements.

(1)(a) A participating RHC shall be currently:

1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

2. Except as established in paragraph (b) of this subsection, participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) To be initially enrolled with the department, an RHC shall:

1. Enroll in accordance with 907 KAR 1:672; and

2. Submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an RHC.

(b) To remain enrolled and participating in the Kentucky Medicaid Program, an RHC shall:

1. Comply with the enrollment requirements established in 907 KAR 1:672;

2. Comply with the participation requirements established in 907 KAR 1:671; and

3. Annually submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an RHC to the department.

(3) An RHC that has been terminated from federal participation shall be terminated from Kentucky Medicaid Program participation.

(4) A participating RHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an RHC.

(5)(a) If an RHC receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 13. Third Party Liability. A provider shall comply with KRS 205.622.

Section 14. 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 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, or 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 15. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 16. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 17. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program rural health clinic (RHC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program RHC

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 coverage provisions and requirements regarding Medicaid Program RHC 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 authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program RHC 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 primary amendment authorizes rural health clinics to provide substance use disorder services and expands these providers' scope of behavioral health services as well as expands the types of practitioners/professionals who can provide behavioral health services in a rural health clinic. Additional amendments include inserting various program integrity requirements such as requiring RHCs to bill third parties for services if a third party is involved and not duplicate bill for a service provided to the recipient by another provider. Other amendments include establishing that RHCs must comply with records maintenance/security requirements and Medicaid provider participation requirements. A new section is added to authorize RHCs to utilize electronic signatures. Another section is added to establish that the coverage provisions and requirements in this administrative regulation are contingent upon federal approval and federal funding. Another new section clarifies that The Department for Medicaid Services (DMS) can audit any claim or medical record or documentation associated with any claim or medical record. Lastly, a section establishing recipient appeal rights regarding an adverse action is added.

(b) The necessity of the amendment to this administrative regulation: The primary amendment – amendment related to substance use disorder services and mental health services – is necessary to comply with a federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." Additionally, the Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange. The Medicaid Program is required to ensure that recipients have access to services. Other amendments are necessary to enhance program integrity requirements, establish that provisions and requirements are contingent upon federal funding (in order to protect state taxpayer generated funds), and establish appeal rights for Medicaid recipients.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(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 complying with an Affordable Care Act mandate, enhancing recipient access

to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Rural health clinics will be affected by this amendment. Additionally, licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide substance use disorder services or the enhanced behavioral health services (established in this amendment) while working for or under contract with an RHC will also be affected by this administrative regulation. Medicaid recipients who qualify for substance use disorder services or the enhanced scope of behavioral health services will be affected by this amendment.

(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. RHCs will need to ensure that they use the practitioners authorized in this administrative regulation to provide the new scope of services (expanded behavioral health services and substance use disorder services) if the given RHC wishes to expand its scope of services accordingly.

(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 anticipated as expanding the scope of services is voluntary.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). RHCs will benefit by being authorized to provide more services. The expanded types of behavioral health practitioners/professionals will benefit by having more employment opportunities in which to provide services. Medicaid recipients will benefit by having enhanced access to behavioral health services including substance use disorder services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in rural health clinics due to the variables involved as DMS cannot estimate how many rural health clinics will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in rural health clinics.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2)

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

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 the amendment to this administrative regulation as will any RHC owned by a local government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many rural health clinics that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in rural health clinics due to the variables involved as DMS cannot estimate how many rural health clinics will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in rural health clinics.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 1:604E

This emergency administrative regulation is being promulgated in conjunction with 907 KAR 1:913E, Repeal of 907 KAR 1:900, as the Department for Medicaid Services (DMS) is adopting a uniform array of services and cost sharing for Medicaid recipients and eliminating the four (4) benefit plans – Comprehensive Choices, Family Choices, Global Choices, and Optimum Choices – to which Medicaid recipients are assigned. DMS is also promulgating this emergency administrative regulation to eliminate premiums for Kentucky Children's Health Insurance Program (KCHIP) participants as the biennium budget suspended the premiums. Additionally, DMS is promulgating this emergency administrative regulation to define preventive services to comport with federal law and regulation as they are federally exempt from cost sharing and to establish that DMS's cost sharing provisions are contingent upon the receipt of federal funding and federal approval. This action must be taken on an emergency basis to comply with federal requirements and with the biennium budget as well as to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

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

907 KAR 1:604E. Recipient cost-sharing.

RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.21, 447.50, 447.52, 447.53, 447.54, 447.59, 457.224, 457.310,

457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-1, 1397aa-1397jj

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50 through 447.82[447.51, 447.53, 447.54, 447.55, 447.57,] 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)

EFFECTIVE: December 26, 2013

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50-447.82[447.51, 447.53, 447.54, 447.55, 447.57,] 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)

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[for the provision of medical assistance to Kentucky's indigent citizenry]. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments [or other similar charges] for Medicaid recipients.[KRS 205.6485(1)(c) requires the cabinet to establish, by administrative regulation, premiums for families with children in the Kentucky Children's Health Insurance Program. 42 U.S.C. 1396r-6(b)(5) allows for a monthly premium in the second six (6) months of transitional medical assistance.] This administrative regulation establishes the provisions relating to Medicaid Program[imposing and collecting] copayments[, coinsurance and premiums from certain recipients].

Section 1. Definitions. (1) ["Coinsurance" means a percentage of the cost of a Medicaid benefit that a recipient is required to pay.

(2) "Comprehensive choices" means a benefit plan for an individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022;

2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or

4. The Model Waiver II Program in accordance with 907 KAR 1:595; and

(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

(3) "Copayment" means a dollar amount representing the portion of the cost of a Medicaid benefit that a recipient is required to pay.

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

(3) "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.

(4) [(5)] "Drug" means a covered drug provided in accordance with 907 KAR 1:019 for which the Department for Medicaid Services provides reimbursement.

(5) "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

(6) "[Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to

1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;

2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of Title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

6. 42 C.F.R. 457.310; and

(b) Has a designated package code of 2, 3, 4, or 5.

(7) [Federal Poverty Level" or "FPL" means guidelines that are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

(7) [(8) "Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive K-TAP benefits and are deprived due to death, incapacity, or absence;

2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or

3. Do not receive K-TAP benefits and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. Receive SSP benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(h) Pregnant women; or

(i) Medicaid works individuals.

(9) "KCHIP" means the Kentucky Children's Health Insurance Program.

(8) [(10)] "KCHIP - Separate Program" means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(9) "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.

(10) [(11)] "K-TAP" means Kentucky's version of the federal block grant program of Temporary Assistance for Needy Families (TANF), a money payment program for children who are deprived of parental support or care due to:

(a) Death;

(b) Continued voluntary or involuntary absence;

(c) Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are in the home; or

(d) Unemployment of one (1) parent if both parents are in the home.

(12) "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 supplemental security income;

(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 20:020; and

(e) Meets the resource standards established in 907 KAR 20:025.

(11)(13) "Nonemergency" means a condition which does not require an emergency service pursuant to 42 C.F.R. 447.53.

(12)(14) "Nonpreferred brand name drug" means a brand name drug that is not on the department's preferred drug list.

(13)(15) "Optimum choices" means a benefit plan for an individual who:

(a) Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. An intermediate care facility for individuals with an intellectual disability in accordance with 907 KAR 1:022; or

2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and

(c) Has a designated package code of S, T, U, V, W, X, Z, O, or 1.

(16) "Preferred brand name[brand-name] drug" means a brand name[brand-name] drug:

(a) For which no generic equivalent exists which has a more favorable cost to the department; and

(b) Which prescribers are encouraged to prescribe, if medically appropriate.

(14) "Preventive service" means:

(a) For a child:

1. An immunization recommended by the Centers for Disease Control; or

2. A preventive service:

a. Rated grade A or B by the United States Preventive Services Task Force (USPSTF); and

b. Recommended for children and adolescents by the USPSTF; or

(b) For an adult, a preventive service:

1. Rated grade A or B by the United States Preventive Services Task Force (USPSTF); and

2. Recommended for adults by the USPSTF.

(15)(17) "Premium" means an amount paid periodically to purchase health care benefits.

(18) "Recipient" is defined in KRS 205.8451 and applies to an individual who has been determined eligible to receive benefits under the state's Title XIX or Title XXI program in accordance with Title 907 KAR[907 KAR Chapters 1 through 4].

(16)(19) "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits[for up to twelve (12) months for families who lose Medicaid eligibility solely because of increased earnings or hours of employment of the caretaker relative or loss of earning disregards] in accordance with 907 KAR 20:005, Section 5(5).

Section 2.[Comprehensive Choices] Copayments[and Coinsurance]. (1) The following table establishes the:

(a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost sharing pursuant to Section 3(1) of this administrative regulation; and

(b)[Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the comprehensive choices plan shall pay the copayment or coinsurance amount established in this table, with the] Corresponding provider reimbursement deductions.

Benefit	Copayment[or Coinsurance] Amount	Amount of Copayment[or Coinsurance] Deducted from Provider Reimbursement
Acute inpatient hospital admission	\$50[\$10] copayment	Full amount of the copayment
Outpatient hospital or ambulatory	\$4[\$3] copayment	Full amount of the copayment

surgical center visit		
Generic prescription drug[or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage]	\$1 copayment	Full amount of the copayment
Preferred brand name drug[for a recipient who does not have Medicare Part D drug coverage]	\$4[\$2] copayment	Full amount of the copayment
Nonpreferred brand name drug[for a recipient who does not have Medicare Part D drug coverage]	\$8[5% coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription]	Full amount of the copayment [coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription]
Emergency room for a nonemergency visit	\$8[5% coinsurance, up to a maximum of \$6]	Full amount of the copayment[No deduction]
DMEPOS	\$4[3% coinsurance up to a maximum of \$15 per item]	Full[The] amount of the copayment [coinsurance or, if applicable, \$15]
Podiatry office visit	\$3[\$2] copayment	Full amount of the copayment
Chiropractic office visit	\$3	Full amount of the copayment
Dental office visit	\$3	Full amount of the copayment
Optometry office visit	\$3	Full amount of the copayment
General ophthalmological office visit	\$3	Full amount of the copayment
Physician office visit	\$3	Full amount of the copayment
Office visit for care by a physician assistant, an advanced practice registered nurse, a certified pediatric and family nurse practitioner, or a nurse midwife	\$3	Full amount of the copayment
Office visit for care by a behavioral health professional	\$3	Full amount of the copayment
Office visit to a rural health clinic	\$3	Full amount of the copayment
Office visit to a federally qualified health center	\$3	Full amount of the copayment
Office visit to a primary care center	\$3	Full amount of the copayment
Physical therapy office visit	\$3	Full amount of the copayment
Occupational therapy office visit	\$3	Full amount of the copayment

Speech therapy office visit	\$3	Full amount of the copayment
Laboratory, diagnostic, or radiological service	\$3	Full amount of the copayment

(2) A recipient shall not be liable for more than:

(a) \$225 per calendar year for prescription drug copayments or coinsurance; or

(b) \$225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five

(5) percent of a family's income for a quarter. (4) If a service or benefit is not listed in the comprehensive choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that service or benefit for an individual in the comprehensive choices benefit plan.]

Section 3. [Family Choices Copayments and Coinsurance.

(1)(a) Except for an individual excluded in accordance with Section 6(1) of this administrative regulation, only KCHIP children shall be family choices individuals subject to copayments or coinsurance.

(b) An individual referenced in paragraph (a) of this subsection shall pay the copayment or coinsurance amounts established in the following table, along with the corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimbursement
Allergy service or testing (no copayment exists for injections)	\$2 copayment	Full amount of copayment
Generic prescription drug or atypical anti-psychotic drug if no generic equivalent exists	\$1 copayment	Full amount of copayment
Preferred brand name drug	\$2 copayment	Full amount of copayment
Nonpreferred brand name drug	\$3 copayment	Full amount of the copayment
Emergency room for a nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction

(2) A recipient shall not be liable for more than:

(a) \$225 per calendar year for prescription drug copayments or coinsurance; or

(b) \$225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five

(5) percent of a family's income for a quarter.

(4) If a service or benefit is not listed in the family choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that service or benefit for an individual in the family choices benefit plan.

Section 4. Global Choices Copayments and Coinsurance. (1)

Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the global choices plan shall pay the copayment or coinsurance amount established in this table, with the corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance	Copayment or Coinsurance Amount Deducted from Provider Reimbursement
Acute inpatient hospital admission	\$50 copayment	Full amount of copayment

Outpatient hospital or ambulatory surgical center visit	\$3 copayment	Full amount of copayment
Laboratory, diagnostic, or radiology service	\$3 copayment	Full amount of copayment
Physician services	\$2 copayment	No deduction
Visit to a rural health clinic, a primary care center, or a federally qualified health center	\$2 copayment	Full amount of copayment
Dental office visit	\$2 copayment	No deduction
Physical therapy	\$2 copayment	Full amount of the copayment
Speech therapy	\$1 copayment	Full amount of the copayment
Chiropractic office visit	\$2 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	\$1 copayment	Full amount of the copayment
Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	\$2 copayment	Full amount of the copayment
Nonpreferred brand name drug for a recipient who does not have Medicare Part D drug coverage	5% coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription	Full amount of the coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription
Emergency room for a nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction
DMEPOS	Three (3) percent coinsurance not to exceed \$15 per item	The amount of the coinsurance or, if applicable, \$15
Podiatry office visit	\$2 copayment	Full amount of the copayment
Ophthalmological or optometric office visit (99000 series evaluation and management codes)	\$2 copayment	Full amount of the copayment

(2) Physician services shall:

(a) Include care provided by a physician, a certified pediatric and family nurse practitioner, a nurse midwife, an advanced registered nurse practitioner, or a physician assistant; and

(b) Not include a visit to a federally qualified health center, rural health clinic, or a primary care center.

(3) A recipient shall not be liable for more than:

(a) \$225 per calendar year for prescription drug copayments or coinsurance; or

(b) \$225 per calendar year for service copayments or coinsurance.

(4) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

(5) If a service or benefit is not listed in the global choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that service for an individual in the global choices benefit plan.

~~Section 5. Optimum Choices Copayments and Coinsurance.~~

(1) Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the optimum choices plan shall pay the copayment or coinsurance amount established in this table, with the corresponding provider reimbursement deductions.

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimbursement
Acute inpatient hospital admission	\$10 copayment	Full amount of the copayment
Outpatient hospital or ambulatory surgical center visit	\$3 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	\$1 copayment	Full amount of the copayment
Preferred brand name drug for a recipient who does not have Medicare Part D drug coverage	\$2 copayment	Full amount of the copayment
Nonpreferred brand name drug for a recipient who does not have Medicare Part D drug coverage	5% coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription	Full amount of the coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription
Emergency room for a nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction
DMEPOS	3% coinsurance up to a maximum of \$15 per item	The amount of the coinsurance or, if applicable, \$15
Podiatry office visit	\$2 copayment	Full amount of the copayment

(2) A recipient shall not be liable for more than:

(a) \$225 per calendar year for prescription drug copayments or coinsurance; or

(b) \$225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

(4) If a service or benefit is not listed in the optimum choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that service or benefit for an individual in the optimum choices benefit plan.

~~Section 6.] Copayment[, Coinsurance and Premium] General Provisions and Exemptions[Exclusions]. (1)(a) A recipient shall not~~

~~be exempt from paying the eight (8) dollar copayment for a nonpreferred brand name drug prescription.~~

~~(b) Except for the mandatory copayment referenced in paragraph (a) of this subsection, the department shall impose no cost sharing for the following:~~

~~1.[(a)] A service furnished to an individual who has reached his or her 18th birthday, but has not turned nineteen (19), and who is required to be provided medical assistance under 42 U.S.C. 1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;~~

~~2.[(b)] A preventive service[for example, well baby and well child care and immunizations] provided to a child under eighteen (18) years of age regardless of family income;~~

~~3.[(c)] A service furnished to a pregnant woman;~~

~~4.[(d)] A service furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o);~~

~~5.[(e)] A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under Kentucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;~~

~~6.[(f)] An emergency service as defined by 42 C.F.R. 447.53;~~

~~7.[(g)] A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or~~

~~8.[(h)] A service furnished to a woman who is receiving medical assistance via the application of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).~~

~~(2) The department has determined that any individual liable for a copayment[, coinsurance amount or premium] shall:~~

~~(a) Be able to pay a required copayment[, coinsurance amount or premium]; and~~

~~(b) Be responsible for a required copayment[, coinsurance or premium].~~

~~(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment[or coinsurance amount] for a recipient.~~

~~(4) A parent or guardian shall be responsible for a copayment[, coinsurance amount or premium] imposed on a dependent child under the age of twenty-one (21).~~

~~(5) Provisions regarding a provider's ability to deny a service or benefit based on a recipient's failure to make a required copayment [or coinsurance payment] shall be as established in:~~

~~(a) KRS 205.6312(4); and~~

~~(b) 2012 Ky. Acts ch. 144, Part I.G.3.b.(14)[2006 Ky. Acts ch. 252 and in accordance with 42 U.S.C. 1396o-1].~~

~~(6) A provider:~~

~~(a) Shall collect from a recipient the copayment[, coinsurance amount or premium] as imposed by the department for a recipient in accordance with this administrative regulation;~~

~~(b) Shall not waive a copayment[, coinsurance amount, or premium] obligation as imposed by the department for a recipient; and~~

~~(c) May collect a copayment[, coinsurance amount, or premium] at the time a benefit is provided or at a later date.~~

~~(7) Cumulative cost sharing for[premium payments and] copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual family income.~~

~~(8) In accordance with 42 C.F.R. 447.82, [A monthly premium for a family who receives benefits under 42 U.S.C. 1396r-6(b) shall not exceed three (3) percent of:~~

~~(a) The family's average gross monthly income; or~~

~~(b) The family's average gross monthly income minus the average monthly costs of child care necessary for the employment of the caretaker relative.~~

(9)] the department shall not increase its reimbursement to a provider to offset an uncollected copayment[, coinsurance amount or premium] from a recipient.[Section 7. Premiums for KCHIP-Separate Program Recipients.

(1) A family with children participating in the KCHIP-Separate Program shall pay a premium of twenty (20) dollars per family, per month.

(2)(a) The family of a new KCHIP-Separate Program eligible shall be required to pay a premium beginning with the first full month of benefits after the month of application.

(b) Benefits shall be effective with the date of application if the premium specified in paragraph (a) of this subsection has been paid.

(3) Retroactive eligibility as described in 907 KAR 20:010, Section 1(3), shall not apply to a recipient participating in the KCHIP-Separate Program.

(4)(a) If a family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(b)1. A KCHIP-Separate Program recipient shall be eligible for reenrollment upon payment of the missed premium.

2. If twelve (12) months have elapsed since a missed premium, a KCHIP-Separate Program recipient shall not be required to pay the missed premium before reenrolling.

Section 8. Premiums for Transitional Medical Assistance Recipients. (1) A family receiving a second six (6) months of TMA, whose monthly countable earned income is greater than 100 percent of the federal poverty limit, shall pay a premium of thirty (30) dollars per family, per month.

(2) If a TMA family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the benefit month for which the premium has not been paid unless the family has established to the satisfaction of the department that good cause existed for failure to pay the premium on a timely basis. Good cause shall exist under the following circumstances:

(a) An immediate family member living in the home was institutionalized or died during the payment month;

(b) The family was victim of a natural disaster including flood, storm, earthquake, or serious fire;

(c) The caretaker relative was out of town for the payment month; or

(d) The family moved and reported the move timely, but the move resulted in:

1. A delay in receiving the billing notice; or
2. Failure to receive the billing notice.]

Section 4.[9.] Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual shall pay a monthly premium that is:

1. Based on income used to determine eligibility for the program; and

2. Established in subsection (2) of this section.

(b) The monthly premium shall be:

1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no more than 150 percent of the FPL;

2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no more than 200 percent of the FPL; and

3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no more than 250 percent of the FPL.

(2) An individual whose family income is equal to or below 100 percent of the FPL shall not be required to pay a monthly premium.

(3) A Medicaid Works individual shall begin paying a premium with the first full month of benefits after the month of application.

(4) Benefits shall be effective with the date of application if the premium specified in subsection (1) of this section has been paid.

(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a Medicaid Works individual.

(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the missed premium providing all

other technical eligibility, income, and resource standards continue to be met.

(8) If twelve (12) months have elapsed since a missed premium, a Medicaid Works individual shall not be required to pay the missed premium before reenrolling.[Section 10. Notices and Collection of Premiums. (1) Premiums shall be collected in accordance with Sections 7, 8, and 9 of this administrative regulation.

(2) The department shall give advance written notice of the:

(a) Premium amount; and

(b) Date the premium is due.

(3) To continue to receive benefits, a family shall pay a premium:

(a) In full; and

(b) In advance.

(4) If a family pays the required premiums semiannually or quarterly in advance, they shall receive a ten (10) percent discount.]

Section 5.[11.] Provisions for Enrollees[Recipients in Medicaid-Managed Care].[(1)] A managed care organization[entity]:

(1)[(a)] Shall not impose[on a recipient receiving services through a managed care entity operating in accordance with 907 KAR 1:705] a copayment on an enrollee[, coinsurance or premium] that exceeds a copayment[, coinsurance or premium] established in this administrative regulation; and

(2)[(b)] May impose on an enrollee[upon a recipient referenced in paragraph (a) of this subsection]:

(a)[1.] A lower copayment[, coinsurance or premium] than established in this administrative regulation; or

(b)[2.] No copayment[, coinsurance or premium. (2) A six (6) month guarantee of eligibility as described in 907 KAR 1:705, Section 3(6)] shall not apply to a recipient required to pay a premium pursuant to Section 7 of this administrative regulation].

Section 6.[12.] Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.

(2) A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

Section 7.[13.] Notice of Discontinuance, Hearings, and Appeal Rights.[(1)] The department shall give written notice of, and an opportunity to pay, past due premiums prior to discontinuance of benefits for nonpayment of a premium.

(2)(a) If a family's income has declined, the family shall submit documentation showing the decline in income.

(b) Following receipt of the documentation, the department shall determine if the family is required to pay the premiums established in Section 7, 8, or 9 of this administrative regulation using the new income level.

(c) If the family is required to pay the premium and the premium has not been paid, the benefits shall be discontinued in accordance with Section 7(4)(a), 8(2), or 9(6) of this administrative regulation.

(d) If the family is not required to pay the premium, benefits shall be continued under an appropriate eligibility category.

(3) The department shall provide the recipient with an opportunity for a hearing in accordance with 907 KAR 1:560 upon discontinuing benefits for nonpayment of premiums.

(4)] An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

Section 8. Effective Date. The cost sharing provisions and requirements established in this administrative regulation shall be effective beginning January 1, 2014.

Section 9. Federal Approval and Federal Funding. The department's copayment provisions established in this administrative regulation shall be contingent upon:

- (1) The receipt of federal financial participation; and
- (2) Centers for Medicare and Medicaid Services' approval.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the cost sharing requirements and provisions for the Kentucky Medicaid program.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the cost sharing requirements and provisions for the Kentucky Medicaid program.

(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 cost sharing requirements and provisions for the Kentucky Medicaid program.

(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 cost sharing requirements and provisions for the Kentucky Medicaid program.

(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 eliminates references to four (4) benefit plans to which Medicaid recipients previously have been assigned (comprehensive choices, family choices, global choices, and optimum choices) along with the corresponding cost sharing for each benefit plan; establishes uniform cost sharing for Medicaid recipients (except for those who are exempt from cost sharing or are enrolled with a managed care organization); eliminates premiums; eliminates references to co-insurance as only copayments, rather than coinsurance, are imposed going forward; establishes that the eight (8) dollar copayment for a nonpreferred brand name drug applies to all Medicaid recipients (no exemptions); establishes that the Department for Medicaid Services (DMS) will reduce the provider's reimbursement by the amount of the copayment for a physician's office visit, dental office visit, and non-emergent emergency room visit (as DMS does with all other copayments); and inserts a definition of preventive services. DMS is repealing a related administrative regulation which establishes the four (4) benefit plans as there was little difference among the plans and the plans created an administrative burden for DMS, providers, and managed care organizations. As a result of eliminating the four (4) benefit plans there will be uniform cost sharing obligations. Cost sharing changes vary based on an individual's benefit plan but include raising the outpatient hospital/ambulatory surgical center copay from three (3) dollars to four (4) dollars, raising the preferred brand name drug copay from two (2) dollars to four (4) dollars, changing the non-preferred brand name drug copay from five (5) percent of the cost (not to exceed twenty (20) dollars to eight (8) dollars, raising the copay for non-emergent care in an emergency room from six (6) dollars to eight (8) dollars, lowering the durable medical equipment copay from no more than fifteen (15) dollars to a fixed copay of four (4) dollars, increasing the podiatry office visit copay from two (2) dollars to three (3) dollars, increasing the dental office visit copay from two (2) dollars to three (3) dollars, raising the ophthalmological and optometry office visit copays from two (2) dollars to three (3) dollars, increasing the physical therapy office

visit from two (2) dollars to three (3) dollars, increasing the speech therapy office visit copay from one (1) dollar to three (3) dollars, establishing an occupational therapy office visit copay of three (3) dollars, increasing the physician's office visit copay from two (2) dollars to three (3) dollars, and increasing the rural health clinic office visit, the federally-qualified health center office visit, and primary care center office visit copays from two (2) dollars to three (3) dollars. DMS no longer imposes premiums for participation in the Kentucky Children's Health Insurance Program (KCHIP); thus, DMS is deleting the provisions regarding premiums.

(b) The necessity of the amendment to this administrative regulation: Eliminating the four (4) benefit plans (and establishing uniform cost sharing provisions) is necessary as the plans have minimal differences in cost sharing and created an administrative burden for the Department for Medicaid Services, providers, and managed care organizations. DMS is eliminating provisions regarding premiums because DMS no longer charges premiums for KCHIP participation as the biennium budget suspended such premiums. Inserting a definition of preventive services is necessary to clarify the services exempt from cost sharing as preventive services for all ages (as mandated by the Affordable Care Act and federal regulation) are exempt from cost sharing. DMS adopted the definition of preventive services that comports with the relevant federal law and regulation. DMS is increasing cost sharing amounts for services as permitted by federal requirements in order to discourage inappropriate utilization of Medicaid services. DMS is not exempting anyone from the eight (8) dollar nonpreferred brand name drug copayment because for such drugs there will always be a preferred brand name drug option and DMS wants to encourage use of preferred brand name drugs over nonpreferred brand name drugs. Reducing provider's reimbursement by the amount of the copayment for physician's office visits, dental office visits, and non-emergent emergency room visits is necessary to comply with federal regulation and directive from the Centers for Medicare and Medicaid Services (CMS). Establishing that DMS's cost sharing is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being spent in the event that federal matching funds are not provided.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by eliminating an administratively burdensome (for DMS and providers) benefit plan structure; complying with federal requirements; complying with the biennium budget; protecting Kentucky taxpayer monies in the event that federal matching funds are not provided; and by discouraging inappropriate utilization of Medicaid services.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by eliminating an administratively burdensome (for DMS and providers) benefit plan structure; complying with federal requirements; complying with the biennium budget; protecting Kentucky taxpayer monies in the event that federal matching funds are not provided; and by discouraging inappropriate utilization of Medicaid services.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid recipients who are not exempt from cost sharing will be affected by the amendment as well as Medicaid providers for whose services cost sharing is applied.

(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. Providers of services for which cost sharing is imposed will be required to impose cost sharing when providing the given service and recipients are responsible for paying cost sharing.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Providers may experience administrative cost

associated with updating the cost sharing amounts per service or costs resulting from a Medicaid recipient refusing to pay a copayment obligation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients who receive preventive services will benefit from the lack of cost sharing applied to the services. Providers will benefit from a uniform cost sharing structure rather than a structure comprised of four (4) benefit plans with varying cost sharing obligations.

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

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost, other than programming changes to its Medicaid Management Information System (MMIS), as a result of the amendment to this administrative regulation.

(b) On a continuing basis: The response to question (a) also applies here.

(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 matching funds from 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 will be necessary to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied in that some Medicaid recipients are exempt (by federal regulation or law) from most cost sharing obligations.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(14), 42 U.S.C. 1396o, 42 C.F.R. 447.50 through 447.60, 42 C.F.R. 447.82, and 42 C.F.R. 438.108

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) authorizes the Cabinet for Health and Family Services 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."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(14) authorizes a state's Medicaid program to impose cost sharing only as allowed by 42 U.S.C. 1396o. 42 U.S.C. 1396o establishes categories of individuals for whom a state's Medicaid program may not impose cost sharing as well as cost sharing and premium limits. 42 C.F.R. 447.50 through 447.60 also establishes limits on cost sharing (based on income of the given Medicaid eligibility group); Medicaid populations exempt from cost sharing (children, pregnant women, institutionalized individuals for example); services exempt from cost sharing (emergency services, family planning services to child-bearing age individuals); prohibition against multiple cost sharing for one (1) service; a requirement that state Medicaid programs do not increase a provider's reimbursement by the amount of cost

sharing; and a requirement that managed care organizations' cost sharing must comply with the aforementioned federal regulations. 42 C.F.R. 447.82 requires a state's Medicaid program to reduce its reimbursement to a provider by the amount of any cost sharing imposed on a recipient for a given service. 42 C.F.R. 438.108 establishes that a managed care organization's cost sharing must comply with the federal cost sharing requirements for Medicaid established in 42 C.F.R. 447.50 through 42 C.F.R. 447.60.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Federal regulations 42 C.F.R. 447.50 through 42 C.F.R. 447.60, 42 C.F.R. 447.82, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates no additional cost, other than programming changes to its Medicaid Management Information System (MMIS), as a result of the amendment to this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) also applies here.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 1:631E

This emergency administrative regulation is being promulgated in conjunction with three (3) other emergency administrative regulations – 907 KAR 1:038E, Hearing program coverage provisions and requirements; 907 KAR 1:039E, Hearing program reimbursement provisions and requirements; and 907 KAR 1:632E, Vision program coverage provisions and requirements, to eliminate annual dollar limits on a benefit (eyeglasses); to establish program integrity provisions; to ensure appropriate utilization of services; and to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding. Currently, the administrative regulation contains annual dollar caps of \$200 and \$400 on eyeglasses. These limits must be eliminated to comply with an Affordable Care Act mandate. The Act prohibits - effective

January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits". Medicaid benefits are within the scope of essential health benefits. This action must be taken on an emergency basis to comply with an Affordable Care Act mandate and to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Emergency Amendment)

907 KAR 1:631E.[Reimbursement of] Vision Program reimbursement provisions and requirements[services].

RELATES TO: KRS 205.520, 42 C.F.R. 440.40, 440.60, 447 Subpart B, 42 U.S.C. 1396a-d

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

EFFECTIVE: December 26, 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes Medicaid Program reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization[provisions for vision services].

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designated agent.

(2) "Enrollee" means a recipient who is enrolled with a managed care organization.

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

(4) "Healthcare common procedure coding system" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services that represent procedures or items.

(5) "Managed care organization" 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.

(6) ["Global Insight Index" means an indication of changes in health care costs from year to year developed by Global Insight.

(3) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(7)[(4)] "Ophthalmic dispenser" means an individual who is qualified to engage in the practice of ophthalmic dispensing in accordance with KRS 326.030 or 326.040.

(8) "Optometrist" is defined by KRS 311.271.

(9) "Provider" is defined by KRS 205.8451(7).

(10) "Recipient" is defined by KRS 205.8541(9)[a physician, optician, or optometrist, who is licensed to prepare and dispense lenses and eyeglasses in accordance with an original, written prescription.

(5) "Resource-based relative value scale unit" or "RBRVS-unit" means a value based on the service which takes into consideration the practitioners' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price].

Section 2. General Requirements. (1)(a) For the department to

reimburse for a vision service or item, the service or item shall be:

1. Provided;

a. To a recipient; and

b. By a provider who:

(i) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Except as established in paragraph (b) of this subsection, is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Is authorized by this administrative regulation to provide the given service or item;

2. Covered in accordance with 907 KAR 1:632;

3. Medically necessary;

4. A service or item authorized within the scope of the provider's licensure; and

5. A service or item listed on the Department for Medicaid Services Vision Program Fee Schedule.

(b) In accordance with 907 KAR 17:010, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) To be recognized as an authorized provider of vision services, an optometrist shall:

1. Be certified by the:

a. Kentucky Board of Optometric Examiners; or

b. Optometric examiner board of the state in which the optometrist practices if the optometrist practices in a state other than Kentucky;

2. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

3. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(b)1. To be recognized as an authorized provider of vision services, an in-state optician shall:

a. Hold a current license in Kentucky as an ophthalmic dispenser;

b. Comply with the requirements established in KRS Chapter 326;

c. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

d. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

2. To be recognized as an authorized provider of vision services, an out-of-state optician shall:

a. Hold a current license in the state in which the optician practices as an ophthalmic dispenser;

b. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

c. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(3)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(4) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(5)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(6) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 3. Reimbursement for Covered Procedures and Materials for Optometrists. (1) ~~Except for~~ [With the exception of materials or] a clinical laboratory service, the department's reimbursement for a covered service or covered item provided by a participating optometrist, within the optometrist's scope of licensure, shall be the lesser of the:

(a) Optometrist's usual and customary charge for the service or item; or

(b) Reimbursement established on the Department for Medicaid Services Vision Program Fee Schedule for the service or item.

(2) The department shall reimburse for a covered clinical laboratory service in accordance with 907 KAR 1:028 [based on the optometrist's usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using the Kentucky Medicaid fee schedule, specified in 907 KAR 3:010, Section 3, developed from a resource-based relative value scale (RBRVS) on parity with physicians.

(2) If an RBRVS based fee has not been established, the department shall set a reasonable fixed upper limit for the procedure. The upper limit shall be determined following a review of rates paid for the service by three (3) other sources. The average of these rates shall be compared with similar procedures paid by the department to set the upper limit for the procedure.

(3) With the exception of the following dispensing services, the department shall use the Kentucky conversion factor for "all nonanesthesia related services" as established in 907 KAR 3:010, Section 3(2)(b):

(a) Fitting of spectacles;

(b) Special spectacles fitting; and

(c) Repair and adjustment of spectacles.

(4) Reimbursement for a dispensing service fee or a repair service fee shall be as follows:

Procedure	Upper Limit
92340 (Fitting of spectacles)	\$33
92341 (Fitting of spectacles)	\$38
92352 (Special spectacles fitting)	\$33
92353 (Special spectacles fitting)	\$39
92370 (Repair & adjust spectacles)	\$29

(5) The department shall:

(a) Reimburse for:

1. A single vision lens at twenty-eight (28) dollars per lens;

2. A bifocal lens at forty-three (43) dollars per lens; and

3. A multi-focal lens at fifty-six (56) dollars per lens; and

(b) Annually adjust the rates established in paragraph (a) of this subsection by the Global Insight Index.

(6)(a) The department shall reimburse for frames or a part of frames (not lenses) at the optical laboratory cost of the materials not to exceed the upper limit for materials as established by the department.

(b) The upper payment limit for frames shall be fifty (50) dollars.

(c) An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for postpayment review.

(7)(a) Reimbursement for a covered clinical laboratory service shall be based on the Medicare allowable payment rates.

(b) For a laboratory service with no established allowable payment rate, the payment shall be sixty-five (65) percent of the

usual and customary actual billed charges].

Section 4.[3.] Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers. The department's reimbursement for a covered service or covered item provided by a participating ophthalmic dispenser [within the ophthalmic dispenser's scope of licensure] shall be the lesser of the:

(1) Ophthalmic dispenser's usual and customary charge for the service or item; or

(2) Reimbursement established on the Department for Medicaid Services Vision Program Fee Schedule for the service or item [in accordance with Section 2 of this administrative regulation].

Section 5.[4.] Reimbursement Limitations. (1) The department shall not reimburse for:

(a) A telephone consultation;

(b) [shall be excluded from payment.

(2) Contact lenses;

(c) [shall be excluded from payment.

(3) Safety glasses unless [shall be covered if] proof of medical necessity is documented;

(d) [

(4) A prism, if medically necessary, shall be added within the cost of the lenses.

(5) A press-on prism; or

(e) A service with a CPT code or item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule [shall be excluded from payment].

(2)(a) The department shall reimburse for no more than one (1) pair of eyeglasses per recipient per twelve (12) consecutive month period unless:

1. The recipient's eyeglasses are broken or lost during the twelve (12) consecutive month period; or

2. The eyeglass prescription for the recipient is changed during the twelve (12) consecutive month period.

(b) If an event referenced in paragraph (a)1 or 2 of this subsection occurs within the twelve (12) consecutive month period, the department shall reimburse for one (1) additional pair of eyeglasses for the recipient during the twelve (12) consecutive month period.

(3) A prism, if medically necessary, shall be included in the cost of lenses.

Section 6.[5.] Third Party Liability. (1) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(2) A provider shall comply with KRS 205.622.

Section 7. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for an item or service reimbursed by the department via this administrative regulation.

Section 8. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 9.[6.] Appeal Rights. A provider may appeal a department decision as to the application of this administrative regulation (1) An appeal of a negative action taken by the department regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907

KAR 1:671.

Section 10. Incorporation by Reference. (1) "Department for Medicaid Services Vision Program Fee Schedule", December 2013, 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, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services' (DMS's) reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(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 DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(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 DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(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 incorporates by reference a fee schedule which contains DMS's reimbursement for vision services; establishes that DMS will reimburse for one (1) pair of eyeglasses per year unless the pair is broken or lost or the prescription changes in which case DMS will reimburse for a second pair (currently, DMS in a related administrative regulation has an annual dollar limit of \$200 or \$400 for eyeglasses depending on the recipient's benefit plan); insert various program integrity measures; and establishes that reimbursement is contingent upon receiving federal approval/funding. This amended administrative regulation is being promulgated in conjunction with three (3) other administrative regulations - 907 KAR 1:632, Vision Program coverage provisions and requirements; 907 KAR 1:038, Hearing program coverage provisions and requirements; and 907 KAR 1:039, Hearing Program reimbursement provisions and requirements. 907 KAR 1:039 currently contains the \$200 and \$400 annual limit on eyeglasses, but vision program provisions are being removed from that administrative regulation as they will be addressed in this administrative regulation.

(b) The necessity of the amendment to this administrative regulation: Establishing a limit of one (1) pair of eyeglasses [or two (2) if the first pair is lost or the recipient's prescription changes] per year rather than an annual dollar cap (\$200 or \$400 as is currently stated in a related administrative regulation) is necessary to comply with an Affordable Care Act mandate. The mandate prohibits, effective January 1, 2014, annual dollar limits on health insurance

benefits that are "essential health benefits." Medicaid program benefits are included in the scope of essential health benefits. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided. Additional amendments are necessary to incorporate various program integrity measures; clarify provisions and requirements; and to provide a user friendly fee schedule of reimbursement.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment will conform to the content of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by inserting program integrity measures; and by clarifying provisions and requirements.

(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 complying with a federal mandate; by preventing a potential loss of state funds; by inserting program integrity measures; and by clarifying provisions and requirements.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect vision service providers participating in the Kentucky Medicaid program. For calendar year 2012, twenty-two (22) opticians billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and 614 optometrists billed claims to the Medicaid program. 7,298 individuals (managed care and fee-for-service combined) received services from opticians in calendar year 2012 and 187,896 individuals received services from optometrists (managed care and fee-for-service combined) during the same period.

(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 the regulated entities other than properly billing for services and not violating program integrity requirements.

(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 may benefit by being allowed to have a pair of eyeglasses per year (with an additional pair allowed if the first pair is lost or the recipient's prescription changes) rather than be subject to a \$200 or \$400 annual cap on eyeglasses. Providers will benefit from a user friendly fee schedule.

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(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, state matching funds, 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: No increase in funding will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes

any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly nor indirectly increases any fees.

(9) Tiering: Is tiering applied? Tiering is applied as eyeglass coverage is only available to those under twenty-one (21). 42 C.F.R. 441.56(c)(1) – which addresses early and periodic screening, diagnosis and treatment (EPSDT services coverage – mandates coverage for individuals under twenty-one (21).

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 447.201, 42 C.F.R. 447.204, 42 C.F.R. 441.56(c)(1), 42 C.F.R. 441.30, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. KRS 194A.050(1) states, "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 205.520(3) states: "... 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. Vision services are not federally mandated except for those under age twenty-one (21) via the early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age twenty-one (21) program pursuant to 42 C.F.R. 441.56(c)(1). 42 C.F.R. 441.30 states, "The plan must provide for payment of optometric services as physician services, whether furnished by an optometrist or a physician, if—

(a) The plan does not provide for payment for services provided by an optometrist, except for eligibility determinations under §§435.531 and 436.531 of this subchapter, but did provide for those services at an earlier period; and

(b) The plan specifically provides that physicians' services include services an optometrist is legally authorized to perform." Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

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.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

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

194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1), .

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 expects that the amendment will not generate revenue.

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

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 1:632E

This emergency administrative regulation is being promulgated in conjunction with three (3) other emergency administrative regulations – 907 KAR 1:631E, Vision program reimbursement provisions and requirements; 907 KAR 1:038E, Hearing program coverage provisions and requirements; and 907 KAR 1:039E, Hearing program reimbursement provisions and requirements;] to eliminate an annual dollar limits on a benefit (eyeglasses); to establish program integrity provisions to ensure appropriate utilization of services; and to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding. Currently, the administrative regulation contains annual dollar caps of \$200 and \$400 on eye glasses. These limits must be eliminated to comply with an Affordable Care Act mandate. The Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits." Medicaid benefits are within the scope of essential health benefits. This action must be taken on an emergency basis to comply with an Affordable Care Act mandate and to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(New Emergency Administrative Regulation)

907 KAR 1:632E. Vision Program coverage provisions and requirements.

RELATES TO: KRS 205.520, 42 C.F.R. 440.40, 440.60, 447 Subpart B, 42 U.S.C. 1396a-d, 45 C.F.R. 147.126

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1)

EFFECTIVE: December 26, 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 Kentucky Medicaid Program provisions and requirements regarding the coverage of vision services.

Section 1. Definitions. (1) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

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

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Healthcare common procedure coding system" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services that represent procedures or items.

(6) "Managed care organization" 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.

(7) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(8) "Ophthalmic dispenser" means an individual who is qualified to engage in the practice of ophthalmic dispensing in accordance with KRS 326.030 or 326.040.

(9) "Optometrist" is defined by KRS 311.271.

(10) "Provider" is defined by KRS 205.8451(7).

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

Section 2. General Requirements. (1)(a) For the department to reimburse for a vision service or item the service or item shall be:

1. Provided:

a. To a recipient; and

b. By a provider who is:

(i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Authorized by this administrative regulation to provide the given service or item;

2. Covered in according with this administrative regulation;

3. Medically necessary;

4. A service or item authorized within the scope of the provider's licensure; and

5. A service or item listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) In accordance with Section 3(3) of 907 KAR 17:010, a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) To be recognized as an authorized provider of vision services, an optometrist shall:

1. Be certified by the:

a. Kentucky Board of Optometric Examiners; or

b. Optometric examiner board in which the optometrist practices if the optometrist practices in a state other than Kentucky;

2. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

3. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(b)1. To be recognized as an authorized provider of vision services, an in-state optician shall:

a. Hold a current license in Kentucky as an ophthalmic dispenser;

b. Comply with the requirements established in KRS Chapter 326;

c. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

d. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

2. To be recognized as an authorized provider of vision services, an out-of-state optician shall:

a. Hold a current license in the state in which the optician practices as an ophthalmic dispenser;

b. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

c. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(3)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department for multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(4) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(5)(a) If a provider receives any duplicate or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(6) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 3. Vision Service Coverage. (1) Vision service coverage shall be limited to a service listed with a CPT code on the Department for Medicaid Services Vision Program Fee Schedule.

(2) Vision service limits shall be as established on the Department for Medicaid Services Vision Program Fee Schedule.

Section 4. Coverage of Eyeglasses and Frames. (1) To be eligible for eyeglasses covered by the department, a recipient shall:

(a) Be under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21) years of

age; and

- (b) Have a diagnosed visual condition that:
 1. Requires the use of eyeglasses;
 2. Is within one (1) of the following categories:
 - a. Amblyopia;
 - b. Post surgical eye condition;
 - c. Diminished or subnormal vision; or
 - d. Other diagnosis which indicates the need for eyeglasses;

and

3. Requires a prescription correction in the stronger lens no weaker than:

- a. +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
- b. 0.50 diopter of vertical prism; or
- c. A total of (two) 2 diopter of lateral prism.

(2)(a) The department shall reimburse for no more than one (1) pair of eyeglasses per recipient per twelve (12) consecutive month period unless:

1. The recipient's eyeglasses are broken or lost during the twelve (12) consecutive month period; or
2. The eyeglass prescription for the recipient is changed during the twelve (12) consecutive month period.

(b) If an event referenced in paragraph (a)1 or 2 occurs within the twelve (12) consecutive month period, the department shall reimburse for one (1) additional pair of eyeglasses for the recipient during the twelve (12) consecutive month period.

(3) For the department to cover:

- (a) A frame, the frame shall be:
 1. First quality;
 2. Free of defects; and
 3. Have a warranty of at least one (1) year; or
- (b) A lens, the lens shall be:
 1. First quality;
 2. Free of defects;

3. Meet the United States Food and Drug Administration's impact resistance standards; and

4. Polycarbonate and scratch coated.
- (4) The dispensing of eyeglasses shall include:

- (a) Single vision prescriptions;
- (b) Bi-focal vision prescriptions;
- (c) Multi-focal vision prescriptions;
- (d) Services to frames; or
- (e) Delivery of the completed eyeglasses which shall include:
 1. Instructions in the use and care of the eyeglasses; and
 2. Any adjustment, minor or otherwise, for a period of one (1) year.

(5) A provider shall be responsible, at no additional cost to the department or the recipient, for:

- (a) An inaccurately filled prescription;
- (b) Defective material; or
- (c) An improperly fitted frame.

Section 5. Contact Lenses, Tint, and Plano Safety Glasses. (1) The department shall not reimburse for contact lenses substituted for eyeglasses unless:

- (a) The corrected acuity in a recipient's stronger eye is twenty (20)/fifty (50) and shall be improved with the use of contact lenses;
 - (b) The visual prescription is of \pm 8.00 diopter or greater; or
 - (c) The recipient's diagnosis is 4.00 diopter anisometropia.
- (2) The department shall not reimburse for tint unless the prescription specifically indicates a diagnosis of photophobia.

(3) The department shall not reimburse for plano safety glasses unless the glasses are medically indicated for the recipient.

Section 6. Noncovered Services or Items. The department shall not reimburse for:

- (1) Tinting if not medically necessary;
- (2) Photochromics if not medically necessary;
- (3) Anti-reflective coatings if not medically necessary;
- (4) Other lens options which are not medically necessary;
- (5) Low vision services;
- (6) A press-on prism; or
- (7) A service with a CPT code or item with an HCPCS code

that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 7. Required Provider Documentation. (1)(a) In accordance with 42 C.F.R. 431.17, a provider shall maintain medical records of a service provided to a recipient for the period of time currently required by the United States Health and Human Services Secretary unless the department requires a retention period, pursuant to 907 KAR 1:671, longer than the period required by the United States Health and Human Services Secretary.

(b) If, pursuant to 907 KAR 1:671, the department requires a medical record retention period longer than the period required by the United States Health and Human Services Secretary, the medical record retention period established in 907 KAR 1:671 shall be the minimum record retention period.

(c) A provider shall maintain medical records of a service provided to a recipient in accordance with:

1. 45 C.F.R. 164.316; and
2. 45 C.F.R. 164.306.

(2) A provider shall maintain the following documentation in a recipient's medical record:

(a) Any covered service or covered item provided to the recipient;

(b) For each covered service or covered item provided to the recipient:

1. A signature by the individual who provided the service or item signed on the date the service or item was provided;
2. The date that the service or item was provided; and
3. Demonstration that the covered service or covered item was provided to the recipient;

(c) The diagnostic condition necessitating the service or item; and

(d) The medical necessity as substantiated by an appropriate medical order.

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 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, or 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 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 upon request.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights. An appeal of a department decision regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

Section 11. Incorporation by Reference. (1) "Department for Medicaid Services Vision Program Fee Schedule", December 2013, 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, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes Medicaid Program coverage policies and requirements regarding vision services. Previously, vision coverage provisions were addressed in 907 KAR 1:038, Hearing Program coverage provisions and requirements, which also established hearing coverage provisions. The Department for Medicaid Services (DMS) is creating this administrative regulation to separate vision coverage provisions from hearing coverage provisions which will remain in 907 KAR 1:038; thus, this administrative regulation is being promulgated in conjunction with 907 KAR 1:038E. Additionally, DMS is promulgating 907 KAR 1:039E, Hearing Program reimbursement provisions and requirements as well as 907 KAR 1:631E, Vision Program reimbursement provisions and requirements in conjunction with this administrative regulation. Though this is a new administrative regulation it does contain amended provisions. The primary amendment is eliminating, from the Vision Program, an annual dollar limit on eyeglasses. Currently, DMS has an annual eyeglass dollar limit of \$200 per year or \$400 per year depending on the recipient's benefit plan; however, DMS is eliminating the dollar limit and establishing that DMS will reimburse for up to two (2) pairs of eyeglasses per twelve (12) consecutive month period [one (1) pair is covered with an additional pair allowed if the individual's glasses are broken or lost or the prescription changes]. Another critical amendment is establishing that DMS's coverage of Vision Program services is contingent upon receipt of federal approval and federal funding. Additional amendments include the elimination of a manual - Vision Program Manual – that DMS incorporated by reference 907 KAR 1:038 and inserting electronic signature requirements to enable providers to sign via electronic signatures. DMS is no longer incorporating the manual by reference into regulation but is incorporating the Department for Medicaid Services Vision Program Fee Schedule by reference into this administrative regulation. The fee schedule limits eye examinations to one (1) per recipient per year in contrast to the current limit of one (1) per recipient per provider per year. The administrative regulation also contains program integrity requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid Program coverage provisions and requirements regarding vision services. Eliminating, from the Vision Program, the \$200 and \$400 annual limits on eye glasses is necessary to comply with a federal mandate. The Affordable Care Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits." Medicaid benefits are within the scope of essential health benefits. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided. Program integrity provisions are necessary to enhance the integrity of the program

and adopting the Vision Program Fee Schedule is necessary to give providers a user friendly document regarding covered 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 Medicaid Program coverage provisions and requirements regarding vision services; by complying with a federal mandate; and by protecting Kentucky taxpayer monies from being spent if federal matching funds are not provided.

(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 coverage provisions and requirements regarding vision services; by complying with a federal mandate; and by protecting Kentucky taxpayer monies from being spent if federal matching funds are not provided.

(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 but it establishes Medicaid Program coverage provisions and requirements regarding vision services that were previously established in another administrative regulation. Please see the response to question (1)(a) for more information..)

(b) The necessity of the amendment to this administrative regulation: Please see the response to question (1)(b).

(c) How the amendment conforms to the content of the authorizing statutes: Please see the response to question (1)(c).

(d) How the amendment will assist in the effective administration of the statutes: Please see the response to question (1)(d).

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect vision service providers participating in the Kentucky Medicaid program. For calendar year 2012, twenty-two (22) opticians billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and 614 optometrists billed claims to the Medicaid program. 7,298 individuals (managed care and fee-for-service combined) received services from opticians in calendar year 2012 and 187,896 individuals received services from optometrists (managed care and fee-for-service combined) during the same period.

(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 the regulated entities other than to properly bill for services and adhere to program integrity requirements.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients who need eyeglasses may benefit from altering the annual cap of \$200 or \$400 to up to two (2) pair of eyeglasses per year (if they meet the qualifying circumstances – the first pair of eyeglasses is lost or broken or the prescription changes.)

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and

2014 will be similar to calendar year 2012 expenditures.

(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, state matching funds, 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: No increase in funding will be necessary to implement this administrative regulation.

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

(9) Tiering: Is tiering applied? Tiering is applied as eyeglass coverage is only available to those under twenty-one (21). 42 C.F.R. 441.56(c)(1) – which addresses early and periodic screening, diagnosis and treatment (EPSDT services coverage – mandates coverage for individuals under twenty-one (21).

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30)(A), 42 U.S.C. 1396a(a)(33), 42 C.F.R. 441.56(c)(1), 42 C.F.R. 441.30, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. Vision services for Medicaid recipients are not mandated by Kentucky law; however, the Department for Medicaid Services is required by KRS 205.8453 to "institute other measures necessary or useful in controlling fraud and abuse." KRS 205.520(3) states: "...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. Vision services are not federally mandated except for those under age twenty-one (21) via the early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age twenty-one (21) program pursuant to 42 C.F.R. 441.56(c)(1). 42 C.F.R. 441.30 states, "The plan must provide for payment of optometric services as physician services, whether furnished by an optometrist or a physician, if:

(a) The plan does not provide for payment for services provided by an optometrist, except for eligibility determinations under §§435.531 and 436.531 of this subchapter, but did provide for those services at an earlier period; and

(b) The plan specifically provides that physicians' services include services an optometrist is legally authorized to perform." Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care.

42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to:

"...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services..."

45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1), and 45 C.F.R. 147.126.

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 expects that the amendment will not generate revenue.

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

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 1:913E

This emergency administrative regulation repeals 907 KAR 1:900 (KyHealth Choices benefit plans). The Department for Medicaid Services (DMS) is eliminating the four (4) benefit plans established in 907 KAR 1:900 in concert with adding new eligibility groups mandated by or authorized by the Affordable Care Act. Previously, when an individual qualified for Medicaid coverage the individual would be assigned to a benefit plan which contained service limits and cost sharing unique to that plan. The four (4) benefit plans vary little and DMS is establishing one (1) benefit package for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. The Affordable Care Act mandates that effective January 1, 2014, the eligibility standard for certain categories of individuals will be a modified adjusted gross income. Additionally, the Affordable Care Act created a new eligibility group comprised of former foster care

individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. That eligibility group is also mandated to become effective January 1, 2014. DMS is repealing the four (4) benefit plans in concert with the new eligibility groups and requirements established by the Affordable Care Act. As Medicaid coverage under the new rules is mandatory January 1, 2014 this repealer administrative regulation must also be effective January 1, 2014. This emergency administrative regulation shall not be replaced by an ordinary administrative regulation as this emergency administrative regulation repeals 907 KAR 1:900 leaving nothing to be repealed by an ordinary administrative regulation. No ordinary administrative regulation is being promulgated.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

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

907 KAR 1:913E. Repeal of 907 KAR 1:900.

RELATES TO: 42 U.S.C. 1396a
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 13A.310(a)
EFFECTIVE: December 26, 2013
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)(a), repeals 907 KAR 1:900. 907 KAR 1:900 is being repealed because it established four (4) benefit plans to which Medicaid recipients have been assigned and the Department for Medicaid Services is eliminating the four (4) benefit plans and establishing, effective January 1, 2014, a uniform structure of services and cost sharing for Medicaid recipients.

Section 1. 907 KAR 1:900, KyHealth Choices benefit plans, is hereby repealed.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY:
FILED WITH LRC:

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, Phone: (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation, in accordance with KRS 13A.310(3)(a), repeals 907 KAR 1:900, KyHealth Choices benefit plans. 907 KAR 1:900 establishes four (4) benefit plans, which varied little, to which Medicaid recipients were assigned. Effective January 1, 2014, the Department for Medicaid Services (DMS), is eliminating the four (4) plans and establishing a uniform benefit and cost sharing structure for Medicaid recipients.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to repeal 907 KAR 1:900, KyHealth Choices benefit plans. 907 KAR 1:900 is being repealed because it establishes four (4) benefit plans to which Medicaid recipients are assigned and DMS is eliminating the four (4) benefit plans. DMS is eliminating the four (4) benefit plans established in 907 KAR 1:900 in concert with adding new eligibility groups mandated by or authorized by the Affordable Care Act. Previously, when an individual qualified for Medicaid coverage the individual would be assigned to a benefit plan which contained service limits and cost sharing unique to that plan. The four (4) benefit plans vary little and DMS is establishing one (1) benefit package for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. The Affordable Care Act mandates that effective January 1, 2014, the eligibility standard for certain categories of individuals will be a modified adjusted gross income. Additionally, the Affordable Care Act created a new eligibility group comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. That eligibility group is also mandated to become effective January 1, 2014. DMS is repealing the four (4) benefit plans in concert with the new eligibility groups and requirements established by the Affordable Care Act. Additionally, there is an administrative and Medicaid Management Information System (MMIS) burden associated with preserving different plans as well as an administrative burden on providers and managed care organizations. Given that the plans vary little it is impractical if not inefficient to preserve the plans.

(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 eliminating an administrative regulation which established four (4) benefit plans to which Medicaid recipients have been assigned as DMS is eliminating the four (4) benefit plans in concert with comports with Affordable Care Act eligibility changes.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by eliminating an administrative regulation which established four (4) benefit plans to which Medicaid recipients have been assigned as DMS is eliminating the four (4) benefit plans in concert with comports with Affordable Care Act eligibility changes.

(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 affects Medicaid recipients in that it eliminates the four (4) benefit

plans in which Medicaid recipients have been assigned for the past several years; however, the plans vary little and eliminating the plans is expected to have little or no actual impact on recipients as all recipients will have the same benefit plan going forward. Medicaid providers are affected in that when they serve a Medicaid recipient, the provider won't have to determine the benefit plan that applies to the given recipient.

(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 or individuals.

(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 or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid providers will benefit by not having to determine the benefit plan of each Medicaid recipient when they provide services to the recipient.

(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. Not applicable, this administrative regulation is being repealed. 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? 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:

STATEMENT OF EMERGENCY 907 KAR 3:005E

This emergency administrative regulation is being promulgated to authorize allergy immunotherapy for all ages (rather than continue to restrict it to individuals under age twenty-one (21) years) as the "alternative benefit plan" (authorized by the Affordable Care Act) adopted by the Department for Medicaid Services on January 1, 2014 does not restrict allergy immunotherapy by age group; to adopt a uniform limit for physical therapy services, occupational therapy and speech pathology services for Medicaid recipients in contrast to the current varied limit based on the individual's benefit plan; and to establish program integrity provisions and safeguards in order to ensure appropriate utilization of services. Additionally, the amended administrative regulation is being promulgated to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to comply with federal requirements regarding an alternative benefit plan and to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Provider Operations (Emergency Amendment)

907 KAR 3:005E. Coverage of physicians' services.

RELATES TO: KRS 205.520, 205.560, 42 C.F.R. 415.152, 415.174, 415.184, 440.50, 447.26, 45 C.F.R. 160, 164, 42 U.S.C. 1320 - 1320d - 8, 1396a(a)(19), (30)

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

EFFECTIVE: December 26, 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 [for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program coverage provisions and requirements [provisions] relating to physicians' services [for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy].

Section 1. Definitions. (1) ["Biological" means the definition of "biologicals" pursuant to 42 U.S.C. 1395x(t)(1).

(2) "Common practice" means a contractual partnership in which a physician assistant administers health care services under the employment and supervision of a physician.

(2) [(3) "Comprehensive choices" means a benefit plan for an

individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022;

2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or

4. The Model Waiver II Program in accordance with 907 KAR 1:595; and

(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

(4) "CPT code" means a code used for reporting procedures and services performed by medical practitioners[physicians] and published annually by the American Medical Association in Current Procedural Terminology.

(3)[(5)] "Department" means the Department for Medicaid Services or its designee.

(4) "Designated controlled substance provider" means the provider designated as a lock-in recipient's controlled substance prescriber pursuant to 907 KAR 1:677.

(5) "Designated primary care provider" means the provider designated as a lock-in recipient's primary care provider pursuant to 907 KAR 1:677.

(6) "Direct physician contact" means that the billing physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(7) "Early and periodic screening and diagnosis and treatment" or "EPSDT" is defined by 42 C.F.R. 440.40(b).["Drug" means the definition of "drugs" pursuant to 42 U.S.C. 1395x(t)(1).]

(8) "Emergency care" means:

(a) Covered inpatient or or[and]-outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or

(b) Emergency ambulance transport.

(9) "Enrollee" means a recipient who is enrolled with a managed care organization.

(10) "Federal financial participation" is defined by 42 C.F.R. 400.203.["EPSDT" means early and periodic screening, diagnosis, and treatment.

(10) "Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to:

(a) 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;

(b) 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

c. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(t)(1)(B);

e. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(t)(1)(C);

d. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(t)(1)(D); or

(e. Has a designated package code of 2, 3, 4, or 5.)

(11) "Global period" means [occurring during] the period of time in which related preoperative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.

(12) ["Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive Kentucky Transitional Assistance Program (K-TAP) benefits and are deprived due to death, incapacity, or absence;

2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or

3. Do not receive K-TAP benefits and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive Supplemental Security Income (SSI) benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. Receive State Supplementations Program (SSP) benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022; or

(h) Pregnant women.

(13) "Graduate medical education program" or "GME Program" means [one (1) of the following]:

(a) A residency program approved by:

1. The Accreditation Council for Graduate Medical Education of the American Medical Association;

2. The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;

3. The Commission on Dental Accreditation of the American Dental Association; or

4. The Council on Podiatric Medicine Education of the American Podiatric Medical Association; or

(b) An approved medical residency program as defined in 42 C.F.R. 413.75(b).

(13)[(44)] "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:

(a) Requires little additional resources; or

(b) Is clinically integral to the performance of the primary procedure.

(14)[(15)] "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.

(15) "Lock-in recipient" means a recipient enrolled in the lock-in program in accordance with 907 KAR 1:677.

(16) ["KenPAC" means the Kentucky Patient Access and Care System.

(17) "KenPAC PCP" means a Medicaid provider who is enrolled as a primary care provider in the Kentucky Patient Access and Care System.

(18) "Locum tenens" means a substitute physician:

(a) Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and

(b) Whose services are paid under the participating physician's provider number.

(17) "Managed care organization" 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.

(18) "Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient as a Medicaid-participating provider in accordance with:

1. 907 KAR 1:671; and

2. 907 KAR 1:672;

(b) The Medicaid Program is the payer for the service; and

(c) The recipient is not liable for payment to the provider for the service other than any cost sharing obligation owed by the recipient to the provider.

(19) "Medical necessity" or "medically necessary" means that a

covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(20) "Medical resident" means ~~one (1) of the following~~:

(a) An individual who participates in an approved graduate medical education (GME) program in medicine or osteopathy; or

(b) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, including:

1. An individual with a:

a. Temporary license;

b. Resident training license; or

c. Restricted license; or

2. An unlicensed graduate of a foreign medical school.

(21) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in Current Procedural Terminology as inappropriate coding of procedure combinations.

(22) "Non-Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient;

(b) The Medicaid Program is not the payer for the service; and

(c) The recipient is liable for payment to the provider for the service.

(23) "Optimum choices" means a benefit plan for an individual who:

(a) Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. An intermediate care facility for individuals with an intellectual disability in accordance with 907 KAR 1:022; or

2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and

(c) Has a designated package code of S, T, U, V, W, X, Z, O, or 1-]

(24) [(23)] "Other licensed medical professional" means a health care provider other than a physician, physician assistant, advanced practice registered nurse [—practitioner], certified registered nurse anesthetist, nurse midwife, or registered nurse who has been approved to practice a medical specialty by the appropriate licensure board.

(25) "Other provider preventable condition" is defined in 42 C.F.R. 447.26(b).

(26) [(24)] "Physician assistant" is defined in KRS 311.840(3).

(27) "Physician injectable drug" means an injectable, infused, or inhaled drug or biological that:

(a) Is not typically self-administered;

(b) Is not excluded as a noncovered immunization or vaccine;

(c) Requires special handling, storage, shipping, dosing, or administration; and

(d) Is a rebatable drug.

(28) "Podiatrist" is defined by KRS 205.510(12).

(29) "Rebatable drug" means a drug for which the drug's manufacturer has entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(30) "Recipient" is defined by KRS 205.8541(9).

(31) [(25)] "Screening" means the evaluation of a recipient by a physician to determine:

(a) If [The presence of] a disease or medical condition is present; and

(b) If further evaluation, diagnostic testing, or treatment is needed.

(32) [(26)] "Special handling, storage, shipping, dosing or administration" means one (1) or more of the following requirements as described in the dosing and administration section of a medication's package insert:

(a) Refrigeration of the medication;

(b) Protection from light until time of use;

(c) Overnight delivery;

(d) Avoidance of shaking or freezing; or

(e) Other protective measures not required for most orally-administered medications.

(27)] "Supervising physician" is defined in KRS 311.840(4).

(33) [(28)] "Supervision" is defined in KRS 311.840(6).

(34) [(29)] "Timely filing" means receipt of a Medicaid claim by the department [—Medicaid]:

(a) Within twelve (12) months of the date the service was provided;

(b) Within twelve (12) months of the date retroactive eligibility was established; or

(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.

(35) [(30)] "Unlisted procedure or service" means a procedure:

(a) For which there is not a specific CPT code; and

(b) Which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Conditions of Participation. (1)(a) A participating physician shall:

1. Be licensed as a physician in the state in which the medical practice is located;

2. Comply with the:

a. Terms and conditions established in 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672;

b. Requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164;

3. Have the freedom to choose whether to provide services to a recipient; and

4. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any service to the recipient.

(b) A provider may provide a service to a recipient on a non-Medicaid basis:

1. If the recipient agrees to receive the service on a non-Medicaid basis; and

2. Whether or not the:

a. Provider is a Medicaid-participating provider; or

b. Service is a Medicaid-covered service.

(2) [—A participating physician shall comply with the terms and conditions established in the following administrative regulations:

(a) 907 KAR 1:005, Nonduplication of payments;

(b) 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions; and

(c) 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation.

(3) A participating physician shall comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.

(4) A participating physician shall have the freedom to choose whether to accept an eligible Medicaid recipient and shall notify the recipient of that decision prior to the delivery of service.] If a [the] provider agrees to provide services to a [accepts the] recipient, the provider:

(a) Shall bill the department [Medicaid] rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Medicaid if the physician informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department on the basis of:

1. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;

2. Incorrect billing procedures, including incorrect bundling of services;

3. Failure to obtain prior authorization for the service; or

4. Failure to meet timely filing requirements.

(3)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the

provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(4)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(5)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(6) A provider shall comply with 45 C.F.R. Part 164.

Section 3. Covered Services. (1) To be covered by the department, a service shall be:

(a) Medically necessary;

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

(c) Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and

(d) Eligible for reimbursement as a physician service.

(2) Direct physician contact between the billing physician and recipient shall not be required for:

(a) A service provided by a;

1. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;

2. (b) A service provided by a Locum tenens physician who provides direct physician contact; or

3. Physician assistant in accordance with Section 7 of this administrative regulation;

(b)(c) A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;

(c)(d) The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;

(d)(e) A [preauthorized] sleep disorder service [if provided in a physician-operated and supervised sleep disorder diagnostic center]; or

(e)(f) A telehealth consultation provided [by a consulting medical specialist] in accordance with 907 KAR 3:170; or

(g) A service provided by a physician assistant in accordance with Section 7 of this administrative regulation.

(3) A service provided by an [individual who meets the definition of] other licensed medical professional shall be covered if the other licensed medical professional is:

(a) [The individual is] Employed by the supervising physician; and

(b) [The individual is] Licensed in the state of practice; and

(c) The supervising physician has direct physician contact with the recipient].

(4) A sleep disorder service shall be covered if performed in:

(a) A hospital; or

(b)1. A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:

a. American Sleep Disorders Association; or

b. American Academy of Sleep Medicine; or

2. An independent diagnostic testing facility that:

a. Is supervised by a physician trained in analyzing and interpreting sleep disorder recordings; and

b. Has documentation demonstrating that it complies with criteria approved by the:

(i) American Sleep Disorders Association; or

(ii) American Academy of Sleep Medicine

Section 4. Service Limitations. (1) A covered service provided to a lock-in recipient [placed in "lock-in" status in accordance with 907 KAR 1:677] shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance prescriber [lock-in provider] unless:

(a) The service represents emergency care; or

(b) The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider [by the "lock-in" provider].

(2) An EPSDT screening service shall be covered in accordance with 907 KAR 11:034 [Sections 3 through 5].

(3) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.

(4) [Except for the following, a drug administered in the physician's office shall not be covered as a separate reimbursable service through the physician program:

(a) Rho (D) immune globulin injection;

(b) An injectable antineoplastic drug;

(c) Medroxyprogesterone acetate for contraceptive use, 150 mg;

(d) Penicillin G benzathine injection;

(e) Ceftriaxone sodium injection;

(f) Intravenous immune globulin injection;

(g) Sodium hyaluronate or hylan G-F for intra-articular injection;

(h) An intrauterine contraceptive device; or

(i) An implantable contraceptive device

(j) Long acting injectable risperidone; or

(k) An injectable, infused or inhaled drug or biological that:

1. Is not typically self-administered;

2. Is not excluded as a noncovered immunization or vaccine; and

3. Requires special handling, storage, shipping, dosing or administration.

(5) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F, shall be covered within the scope and limitations of 42 C.F.R. 441, Subpart E and Subpart F [the federal regulations].

(5)(6) Coverage for:

(a) A service designated as a psychiatry service CPT code and provided by a physician other than a board certified or board eligible psychiatrist or an advanced practice registered nurse with a specialty in psychiatry shall be limited to four (4) services, per physician, per recipient, per twelve (12) months;

(b) [:

(7)(a) Coverage for] An evaluation and management service shall be limited to one (1) per physician, per recipient, per date of service; or

(c) [:

(b) Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician.

(8) Coverage for] A fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(6)(9)(a) An anesthesia service shall be covered if:

(a) Administered by:

1. An anesthesiologist who remains in attendance throughout the procedure; or

2. An individual who:

a. Is licensed in Kentucky to practice anesthesia;

b. Is licensed in Kentucky within his or her scope of practice; and

c. Remains in attendance throughout the procedure;

~~(b) Medically necessary; and~~
~~(c) Not provided as part of an all-inclusive CPT code.~~
~~(7) [administered by an anesthesiologist who remains in attendance throughout the procedure;~~
~~(b) Except for An anesthesia service provided by an oral surgeon, an anesthesia service, including conscious sedation, provided by a physician performing the surgery shall not be covered.~~
~~(10) The following [services] shall not be covered:~~
~~(a) An acupuncture service;~~
~~(b) [Allergy immunotherapy for a recipient age twenty-one (21) years or older;~~
~~(c) An autopsy;~~
~~(c) [(d)] A cast or splint application in excess of the limits established in 907 KAR 3:010, Section 4(5) and (6);~~
~~(d) [(e)] Except for therapeutic bandage lenses, contact lenses;~~
~~(e) [(f)] A hysterectomy performed for the purpose of sterilization;~~
~~(f) [(g)] Lasik surgery;~~
~~(g) [(h)] Paternity testing;~~
~~(h) [(i)] A procedure performed for cosmetic purposes only;~~
~~(i) [(j)] A procedure performed to promote or improve fertility;~~
~~(j) [(k)] Radial keratotomy;~~
~~(k) [(l)] A thermogram;~~
~~(l) [(m)] An experimental service which is not in accordance with current standards of medical practice; [or]~~
~~(m) [(n)] A service which does not meet the requirements established in Section 3(1) of this administrative regulation;~~
~~(n) Medical direction of an anesthesia service; or~~
~~(o) Medical assistance for an other provider preventable condition in accordance with 907 KAR 14:005.~~

Section 5. Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization [and KenPAC Referral Requirements]. (1) The following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:

(a) Magnetic resonance imaging [(MRI)];
 (b) Magnetic resonance angiogram [(MRA)];
 (c) Magnetic resonance spectroscopy;
 (d) Positron emission tomography [(PET)];
 (e) Cineradiography or videoradiography [video radiography];
 (f) Xeroradiography;
 (g) Ultrasound subsequent to second obstetric ultrasound;
 (h) Myocardial imaging;
 (i) Cardiac blood pool imaging;
 (j) Radiopharmaceutical procedures;
 (k) Gastric restrictive surgery or gastric bypass surgery;
 (l) A procedure that is commonly performed for cosmetic purposes;
 (m) A surgical procedure that requires completion of a federal consent form; or
 (n) An unlisted covered procedure or service.
 (2)(a) Prior authorization by the department shall not be a guarantee of recipient eligibility.
 (b) Eligibility verification shall be the responsibility of the provider.
 (3) The prior authorization requirements established in subsection (1) of this section shall not apply to:
 (a) An emergency service; or
 (b) A radiology procedure if the recipient has a cancer or transplant diagnosis code.
 (4) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse;
 (a) [practitioner] May request prior authorization from the department; and
 (b) If requesting prior authorization, :-
 (5) A referring physician, a physician who wishes to provide a given service, or an advanced registered nurse practitioner shall request prior authorization by:
 1. Mailing or faxing:
 a. [(a)] A written request to the department with

[sufficient] information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and

b. [(b)] If applicable, any required federal consent forms; or
 2. Submitting a request via the department's web-based portal with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation. [(6) Except for a service specified in 907 KAR 1:320, Section 10(3)(a) through (g), a referral from the KenPAC PCP shall be required for a recipient enrolled in the KenPAC Program.]

Section 6. Therapy Service Limits. (1) Speech language pathology services [therapy] shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section]:

(a) Ten (10) visits per twelve (12) months for a recipient of the Global Choices benefit plan;

(b) Thirty (30) visits per twelve (12) months for a recipient of the:

1. Comprehensive Choices benefit plan; or
2. Optimum Choices benefit plan].

(2) Physical therapy services shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section]:

(a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices benefit plan; or

(b) Thirty (30) visits per twelve (12) months for a recipient of the:

1. Comprehensive Choices benefit plan; or
2. Optimum Choices benefit plan].

(3) Occupational therapy services shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section]:

(a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices benefit plan; or

(b) Thirty (30) visits per twelve (12) months for a recipient of the:

1. Comprehensive Choices benefit plan; or
2. Optimum Choices benefit plan].

(4) A service in excess of the [therapy] limits established in subsection (1) through (3) of this section shall be exceeded [overridden] if the additional service is determined to be medically necessary by:

(a) The department if the recipient is not enrolled with a managed care organization; or

(b) Managed care organization in which the enrollee is enrolled if the recipient is an enrollee [determines that additional visits beyond the limit are medically necessary. (5)(a) To request an override:

1. The provider shall telephone or fax the request to the department; and

2. The department shall review the request in accordance with the provisions of 907 KAR 3:130 and notify the provider of its decision.

(b) An appeal of a denial regarding a requested override shall be in accordance with 907 KAR 1:563.

(6) The limits established in subsections (1), (2), and (3) of this section shall not apply to a recipient under twenty-one (21) years of age. Except for recipients under age twenty-one (21), prior authorization shall be required for each visit that exceeds the limit established in subsection (1) through (3) of this section].

Section 7. Physician Assistant Services. (1) Except for [With the exception of] a service limitation specified in subsections (2) or (3) of this section, a service provided by a physician assistant in common practice with a Medicaid-enrolled physician shall be covered if:

(a) The service meets the requirements established in Section 3(1) of this administrative regulation;

(b) The service is within the legal scope of certification of the physician assistant;

(c) The service is billed under the physician's individual provider number with the physician assistant's number included;

and

(d) The physician assistant complies with:

1. KRS 311.840 to 311.862; and

2. Section 2(1)(b)[Sections 2(2) and (3)] of this administrative regulation.

(2) A same service performed by a physician assistant and a physician on the same day within a common practice shall be considered as one (1) covered service.

(3) The following physician assistant services shall not be covered:

(a) A physician noncovered service specified in Section 4(9)[Section 4(10)] of this administrative regulation;

(b) An anesthesia service;

(c) An obstetrical delivery service; or

(d) A service provided in assistance of surgery.

Section 8. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the same service provided to the same recipient during the same time period via the physician services program.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. 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 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, or 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 11. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 12. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 13. Appeal Rights. [(1)] An appeal of a department decision regarding:

(1) A Medicaid recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563; or

(2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 17:010. [(2) An appeal of a department decision regarding Medicaid eligibility of an

individual shall be in accordance with 907 KAR 1:560.

(3) 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: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding physician services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program coverage provisions and requirements regarding physician 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 Medicaid program coverage provisions and requirements regarding physician 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 authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding physician 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 amendments include authorizing Medicaid reimbursement for allergy immunotherapy for all ages [the current version of the administrative regulation does not authorize such coverage for individuals twenty-one (21) and over]; revising the speech pathology service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; revising the physical therapy service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; revising the occupational therapy service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; deleting references to the four (4) Medicaid benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years; establishing that the Department for Medicaid Services (DMS) won't reimburse for medical direction of an anesthesia service and won't reimburse for an anesthesia service that is included as part of an all-inclusive CPT code; establishing that a sleep disorder service must be performed in a hospital, sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the American Sleep Disorders Association or American Academy of Sleep Medicine, or independent diagnostic testing facility that is supervised by a physician training in analyzing and interpreting sleep disorder recordings and if the testing facility has the aforementioned documentation required for

sleep laboratories; establishing that DMS won't reimburse for an "other provider preventable condition" (this is a condition which resulted from a provider's neglect and was not present in the recipient when the recipient appeared at the provider's office to receive a service); adding podiatrists and chiropractors as providers eligible to request prior authorization for a service; establishing an option for providers to request prior authorization for services through an internet portal; establishing that the Department for Medicaid Services' (DMS's) coverage of services is contingent upon federal approval and funding; and establishing that the relevant administrative regulation for services' related appeals for an individual who is enrolled with a managed care organization is 907 KAR 17:010.

(b) The necessity of the amendment to this administrative regulation: The amendment which eliminates the age cap on allergy immunotherapy and the amendment which sets a uniform limit of twenty (20) therapy service visits per calendar year are necessary to synchronize DMS's coverage of therapy services and of allergy immunotherapy with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year and covers allergy immunotherapy for all ages, DMS is adopting the same policies. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) Consequently, DMS is concurrently repealing the administrative regulation which establishes the four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years. The four (4) benefit plans vary little and DMS is establishing one (1) benefit plan for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. Additionally, there is an administrative and Medicaid Management Information System (MMIS) burden associated with preserving different plans as well as an administrative burden on providers and managed care organizations. Given that the plans vary little it is impractical if not inefficient to preserve the plans. The amendments regarding anesthesia are necessary to ensure appropriate utilization of services. The amendment regarding a sleep disorder service is necessary to ensure recipients are served by a provider that meets national industry standards. Establishing that DMS won't reimburse for an "other provider preventable condition" is necessary to comply with a federal mandate. Authorizing chiropractors and podiatrists to request prior authorization is necessary to enhance recipient access to services; establishing an option for providers to request prior authorization online is necessary to expedite the delivery of services; establishing that DMS's coverage of services is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer monies; and establishing that appeals for a recipient enrolled with a managed care organization will be done in accordance with the relevant managed

care organization regulation is necessary as such appeals are in the domain of managed care organizations.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with the Affordable Care Act, enhancing the health, safety, and welfare of Medicaid recipients, facilitating providers' ability to request prior authorizations, and protecting Kentucky taxpayer monies.

(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 comporting with the Affordable Care Act, enhancing the health, safety, and welfare of Medicaid recipients, facilitating providers' ability to request prior authorizations, and protecting Kentucky taxpayer monies.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The administrative regulation affects physicians enrolled in the Medicaid program. Currently, there are over 14,000 individual physicians and over 1,700 physician group practices participating in the Medicaid Program. Medicaid recipients who receive services (including physical therapy services, speech pathology services, or sleep disorder services) will be affected by the amendment.

(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 by providers other than to ensure that they provide services appropriately in accordance with the program requirements.

(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 providers.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): As a result of complying with the administrative regulation, Medicaid-enrolled physicians will be reimbursed for services provided to Medicaid recipients.

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

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost as a result of the amendment.

(b) On a continuing basis: DMS anticipates no additional cost as a result of the amendment.

(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 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: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

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

(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.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10), 42 U.S.C. 1396a(a)(19), and 42 C.F.R. 447.26.

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. 42 U.S.C. 1396a(a)(10) mandates that a state's Medicaid Program cover physician services. 42 U.S.C. 1396a(a)(19) requires Medicaid programs to provide care and services consistent with the best interests of Medicaid recipients.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect all physicians enrolled in the Medicaid program who are not reimbursed via a managed care organization.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 42 C.F.R. 447.26 and 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 amendment will not generate any additional revenue for state or local governments during the first year of implementation.

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

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional 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.

STATEMENT OF EMERGENCY 907 KAR 8:005E

This emergency administrative regulation is being promulgated in conjunction with six (6) other administrative regulations – 907 KAR 8:010E, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:015E, Independent occupational therapy service reimbursement provisions and requirements; 907 KAR 8:020E, Independent physical therapy service coverage provisions and requirements; 907 KAR 8:025E, Independent physical therapy service reimbursement provisions and requirements; 907 KAR 8:030E, Independent speech pathology service coverage provisions and requirements; and 907

KAR 8:035E, Independent speech pathology service reimbursement provisions and requirements – to expand the base of therapy service providers to ensure that Medicaid recipients have access to these services in accordance with federal requirements. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (New Emergency Administrative Regulation)

907 KAR 8:005E. Definitions for 907 KAR Chapter 8.

RELATES TO: 194A.025(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

EFFECTIVE: December 26, 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 a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the definitions for administrative regulations in 907 KAR Chapter 8.

Section 1. Definitions. (1) "Adult" means an individual who is at least twenty-one (21) years of age.

(2) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(3) "Child" means an individual who is under twenty-one (21) years of age.

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

(5) "Electronic signature" is defined by KRS 369.102(8).

(6) "Enrollee" means a recipient who is enrolled with a managed care organization.

(7) "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.

(8) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

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

(10) "Occupational therapy assistant" is defined by KRS 319A.010(4).

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

(12) "Physician assistant" is defined by KRS 311.840(3).

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

(14) "Physical therapy 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.

(15) "Prior authorized" means authorized by:

(a) The department if the service is for a recipient who is not an enrollee; or

(b) A managed care organization if the service is for an enrollee.

(16) "Provider" is defined by KRS 205.8451(7).

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

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

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy. The Department for Medicaid Services currently covers these therapies in various settings (for example, home health agencies, physician's offices, outpatient hospitals, nursing facilities) but does not allow these practitioners to enroll as independent providers in the Medicaid Program. Instead, the practitioners have to work for or under contract with a provider type (such as the aforementioned) that is authorized to provide therapy. DMS is promulgating, in conjunction with this administrative regulation, six (6) other administrative regulations which will authorize occupational therapists, physical therapists, and speech language pathologists to enroll in the Medicaid Program, provide services to Medicaid recipients, and be reimbursed directly by the Medicaid Program for the services. The six (6) other administrative regulations are 907 KAR 8:010, Occupational therapy coverage provisions and requirements; 907 KAR 8:015, Reimbursement for occupational therapy; 907 KAR 8:020, Physical therapy coverage provisions and requirements; 907 KAR 8:025, Reimbursement for physical therapy; 907 KAR 8:030, Speech therapy coverage provisions and requirements; and 907 KAR 8:035, Reimbursement for speech therapy.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any occupational therapist, physical therapist, or speech-language pathologist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for services provided to Medicaid recipients. The Department for Medicaid Services (DMS) is unable to predict how many such individuals will choose to enroll in the Medicaid Program.

(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. An occupational therapist, a physical therapist, or a speech-language pathologist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). An occupational therapist, a physical therapist, or a speech-language pathologist therapist who wishes to provide services to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An occupational therapist, a physical therapist, or a speech-language pathologist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients.

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

(a) Initially: No cost is necessary to initially implement this administrative regulation as it is simply a definitions administrative regulation.

(b) On a continuing basis: No continuing cost is necessary to implement this administrative regulation as it is simply a definitions administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

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

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions for 907 KAR Chapter 8.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation.

2. State compliance standards. KRS 194A.030(2) states, "The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act."

3. Minimum or uniform standards contained in the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation. There is; however, a mandate to ensure recipient access to services covered by the state's

Medicaid program. As the Department for Medicaid Services (DMS) covers occupational therapy services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

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? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this administrative regulation in the first year.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary in subsequent years to implement this administrative regulation.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 8:010E

This emergency administrative regulation is being promulgated in conjunction with six (6) other administrative regulations – 907 KAR 8:005E, Definitions for 907 KAR Chapter 8; 907 KAR 8:015E, Independent occupational therapy service reimbursement provisions and requirements; 907 KAR 8:020E; Independent physical therapy service coverage provisions and requirements; 907 KAR 8:025E, Independent physical therapy service reimbursement provisions and requirements; 907 KAR 8:030E, Independent speech pathology service coverage provisions and requirements; and 907 KAR 8:035E, Independent speech pathology service reimbursement provisions and requirements – to

expand the base of therapy service providers to ensure that Medicaid recipients have access to these services in accordance with federal requirements. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (New Emergency Administrative Regulation)

907 KAR 8:010E. Independent occupational therapy service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding occupational therapy services provided by an independent occupational therapist or occupational therapy assistant working under the direct supervision of an independent occupational therapist.

Section 1. Provider Participation. (1)(a) To be eligible to provide and be reimbursed for an occupational therapy service as an independent provider, a provider shall be:

1. Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

2. Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

3. An occupational therapist.

(b) In accordance with 907 KAR 17:010, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2) Occupational therapy services provided in accordance with Section 2 of this administrative regulation by an occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in subsection (1) of this section shall be reimbursable if the occupational therapist is the biller for the services.

Section 2. Coverage and Limit. (1) The department shall reimburse for an occupational therapy service if:

(a) The service:

1. Is provided:

a. By an:

(i) Occupational therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level;

3. Is prior authorized; and
4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by an occupational therapist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or
2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each service visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 3. No Duplication of Service. (1) The department shall not reimburse for an occupational therapy service provided to a recipient by more than one (1) provider of any program in which occupational therapy services are covered during the same time period.

(2) For example, if a recipient is receiving an occupational therapy service from an occupational therapist enrolled with the Medicaid Program, the department shall not reimburse for the same occupational therapy service provided to the same recipient during the same time period via the home health program.

Section 4. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2) A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(3) The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(4)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(5) A provider shall comply with 45 C.F.R. Chapter 164.

Section 5. Medicaid Program Participation Compliance. (1) A provider shall comply with:

- (a) 907 KAR 1:671;
- (b) 907 KAR 1:672; and
- (c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 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 8. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and

- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program coverage of occupational therapy services provided by an independently enrolled occupational therapist or occupational therapy assistant working under the direct supervision of an independently enrolled occupational therapist. Currently, the Department for Medicaid Services (DMS) covers occupational therapy services when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This authorizes occupational therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for occupational therapy services provided to Medicaid recipients. DMS is expanding the occupational therapy service provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19)

and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. Additionally, DMS anticipates many individuals who previously qualified for Medicaid benefits, but did not apply for benefits will seek benefits as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:015, Independent occupational therapy service reimbursement provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of occupational therapy service providers in order to meet the demand for care (thus, to ensure recipient access to care.) The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133% of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Additionally, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any occupational therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for occupational therapy services provided to Medicaid recipients. Similarly, occupational therapy assistants who wish to work for/under the supervision of an independently enrolled occupational therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of occupational therapy services will be affected by the administrative regulation. The Department for Medicaid Services

(DMS) is unable to predict how many occupational therapists will choose to enroll in the Medicaid Program, nor how many occupational therapy assistants will elect to work for/under the supervision of an independently enrolled occupational therapists, nor how many Medicaid recipients will receive services from independently enrolled occupational therapists.

(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. An occupational therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). An occupational therapist who wishes to provide occupational therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An occupational therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Occupational therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of occupational therapy services will benefit from an expanded base of providers from which to receive occupational therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover occupational therapy services; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers occupational therapy services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 8:015E

This emergency administrative regulation is being promulgated in conjunction with six (6) other administrative regulations – 907 KAR 8:005E, Definitions for 907 KAR Chapter 8; 907 KAR 8:010E, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:020E, Independent physical therapy service coverage provisions and requirements; 907 KAR 8:025E, Independent physical therapy service reimbursement provisions and requirements; 907 KAR 8:030E, Independent speech pathology service coverage provisions and requirements; and 907 KAR 8:035E, Independent speech pathology service reimbursement provisions and requirements – to expand the base of therapy service providers to ensure that Medicaid recipients have access to these services in accordance with federal requirements. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (New Emergency Administrative Regulation)

907 KAR 8:015E. Independent occupational therapy service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding occupational therapy services provided by an independent occupational therapist, or an occupational therapy assistant working under the direct supervision of an independent occupational therapist, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. (1) For the department to reimburse for an occupational therapy service under this administrative regulation, the:

(a) Occupational therapist shall meet the provider requirements established in 907 KAR 8:010; and

(b) Service shall meet the coverage and related requirements established in 907 KAR 8:010.

(2) Occupational therapy services provided in accordance with 907 KAR 8:010 and by an occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in 907 KAR 8:010 shall be reimbursable if the occupational therapist is the biller for the therapy.

Section 2. Reimbursement. The department shall reimburse for an occupational therapy service provided by an:

(1) Occupational therapist, in accordance with 907 KAR 8:010 and Section 2 of this administrative regulation, at 63.75 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule; or

(2) Occupational therapy assistant working for an occupational

therapist, in accordance with 907 KAR 8:010 and Section 2 of this administrative regulation, at 37.5 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

- (1) 907 KAR 8:010; and
- (2) This administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the reimbursement; and
- (2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

- (1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding occupational therapy services provided by an independently enrolled occupational therapists, or occupational therapy assistant working under the direct supervision of an independently enrolled occupational therapist, to Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for occupational therapy services pursuant to this administrative regulation. Currently, the Department for Medicaid Services (DMS) covers occupational therapy services when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This administrative regulation authorizes occupational therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for occupational therapy services provided to Medicaid recipients. DMS is expanding the occupational therapy service provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. DMS must expand its provider base to meet the demand of the additional Medicaid recipients DMS anticipates beginning January 1, 2014 (in order to ensure recipient access to care.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:010, Independent occupational therapy service coverage provisions and requirements

and 907 KAR 8:005, Definitions for KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of occupational therapy service providers in order to meet the demand for care (thus, to ensure recipient access to care.)

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any occupational therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for occupational therapy services provided to Medicaid recipients. Similarly, occupational therapy assistants who wish to work for/under the supervision of an independently enrolled occupational therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of occupational therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many occupational therapists will choose to enroll in the Medicaid Program, nor how many occupational therapy assistants will elect to work for/under the supervision of an independently enrolled occupational therapists, nor how many Medicaid recipients will receive services from independently enrolled occupational therapists.

(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. An occupational therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). An occupational therapist who wishes to provide occupational therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An occupational therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Occupational therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of occupational therapy services will benefit from an

expanded base of providers from which to receive occupational therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover occupational therapy services; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers occupational therapy services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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

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

STATEMENT OF EMERGENCY 907 KAR 8:020E

This emergency administrative regulation is being promulgated in conjunction with six (6) other administrative regulations – 907 KAR 8:005E, Definitions for 907 KAR Chapter 8; 907 KAR 8:010E, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:015E, Independent occupational therapy service reimbursement provisions and requirements; 907 KAR 8:025E, Independent physical therapy service reimbursement provisions and requirements; 907 KAR 8:030E, Independent speech pathology service coverage provisions and requirements; and 907 KAR 8:035E, Independent speech pathology service reimbursement provisions and requirements – to expand the base of therapy service providers to ensure that Medicaid recipients have access to these services in accordance with federal requirements. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (New Emergency Administrative Regulation)

907 KAR 8:020E. Independent physical therapy service coverage provisions and requirements.

RELATES TO: KRS 205.520
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1),

205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding physical therapy services provided by an independent physical therapist or physical therapy assistant working under the direct supervision of an independent physical therapist.

Section 1. Provider Participation. (1)(a) To be eligible to provide and be reimbursed for physical therapy as an independent provider, a provider shall be:

1. Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

2. Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

3. A physical therapist.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2) Physical therapy provided in accordance with Section 2 of this administrative regulation by a physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in subsection (1) of this section may be reimbursable if the physical therapist is the biller for the therapy.

Section 2. Coverage and Limit. (1) The department shall reimburse for physical therapy if:

(a) The therapy:

1. Is provided:

a. By a:

(i) Physical therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level;

3. Is prior authorized; and

4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by a physical therapist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) physical therapy visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each therapy visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 3. No Duplication of Service. (1) The department shall not reimburse for physical therapy provided to a recipient by more than one (1) provider of any program in which physical therapy is

covered during the same time period.

(2) For example, if a recipient is receiving physical therapy from a physical therapist enrolled with the Medicaid Program, the department shall not reimburse for physical therapy provided to the same recipient during the same time period via the home health program.

Section 4. Records Maintenance, Protection, and Security.

(1)(a) A provider shall maintain a current health record for each recipient;

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service; and

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years; and

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Part 164.

Section 5. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 8. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program coverage of physical therapy provided by an independently enrolled physical therapist or physical therapy assistant working under the direct supervision of an independently enrolled physical therapist. Currently, the Department for Medicaid Services (DMS) covers physical therapy when provided in a physician's office (and the physician is the billing entity), when provided in an outpatient hospital (when the outpatient hospital is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This authorizes physical therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for physical therapy provided to Medicaid recipients. DMS is expanding the physical therapy provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. Additionally, DMS anticipates many individuals who previously qualified for Medicaid benefits, but did not apply for benefits will seek benefits as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:025, Independent physical therapy service reimbursement provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of physical therapy providers in order to meet the demand for care (thus, to ensure recipient access to care.) The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining

Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133% of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Additionally, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any physical therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for physical therapy services provided to Medicaid recipients. Similarly, physical therapy assistants who wish to work for/under the supervision of an independently enrolled physical therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of physical therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many physical therapists will choose to enroll in the Medicaid Program, nor how many physical therapy assistants will elect to work for/under the supervision of an independently enrolled physical therapists, nor how many Medicaid recipients will receive services from independently enrolled physical therapists.

(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 physical therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A physical therapist who wishes to provide physical therapy to Medicaid recipients could experience administrative

costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A physical therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Physical therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of physical therapy services will benefit from an expanded base of providers from which to receive physical therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover physical therapy; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers physical therapy, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." "Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 8:025E

This emergency administrative regulation is being promulgated in conjunction with six (6) other administrative regulations – 907 KAR 8:005E, Definitions for 907 KAR Chapter 8; 907 KAR 8:010E, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:015E, Independent occupational therapy service reimbursement provisions and requirements; 907 KAR 8:020E, Independent physical therapy service coverage provisions and requirements; 907 KAR 8:030E, Independent speech pathology service coverage provisions and requirements; and 907 KAR 8:035E, Independent speech pathology service reimbursement provisions and requirements – to expand the base of therapy service providers to ensure that Medicaid recipients have access to these services in accordance with federal requirements. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(New Emergency Administrative Regulation)

907 KAR 8:025E. Physical therapy service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding physical therapy services provided by an independent physical therapist, or physical therapy assistant working under the direct supervision of an independent physical therapist, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. (1) For the department to reimburse for physical therapy under this administrative regulation, the:

(a) Physical therapist shall meet the provider requirements established in 907 KAR 8:020; and

(b) Physical therapy shall meet the coverage and related requirements established in 907 KAR 8:020.

(2) Physical therapy provided in accordance with 907 KAR 8:020 and by a physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in 907 KAR 8:020 shall be reimbursable if the physical therapist is the biller for the therapy.

Section 2. Reimbursement. The department shall reimburse for a physical therapy service provided by a:

(1) Physical therapist, in accordance with 907 KAR 8:020 and Section 2 of this administrative regulation, at 63.75 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule; or

(2) Physical therapy assistant working for a physical therapist, in accordance with 907 KAR 8:020 and Section 2 of this administrative regulation, at 37.5 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 8:020; and

(2) This administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort,

Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding physical therapy services provided by an independently enrolled physical therapist, or physical therapy assistant working under the direct supervision of an independently enrolled physical therapist, to Medicaid recipients who are not enrolled with a managed care organization.. Managed care organizations are not required to reimburse for physical therapy services pursuant to this administrative regulation. Currently, the Department for Medicaid Services (DMS) covers physical therapy when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in an outpatient hospital (billed by the outpatient hospital), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This administrative regulation authorizes physical therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for physical therapy provided to Medicaid recipients. DMS is expanding the physical therapy provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. DMS must expand its provider base to meet the demand of the additional Medicaid recipients DMS anticipates beginning January 1, 2014 (in order to ensure recipient access to care.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:020, Independent physical therapy service coverage provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of physical therapy providers in order to meet the demand for care (thus, to ensure recipient access to care.)

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather

than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any physical therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for physical therapy services provided to Medicaid recipients. Similarly, physical therapy assistants who wish to work for/under the supervision of an independently enrolled physical therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of physical therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many physical therapists will choose to enroll in the Medicaid Program, nor how many physical therapy assistants will elect to work for/under the supervision of independently enrolled physical therapists, nor how many Medicaid recipients will receive services from independently enrolled physical therapists.

(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 physical therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A physical therapist who wishes to provide physical therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A physical therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Physical therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of physical therapy services will benefit from an expanded base of providers from which to receive physical therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover physical therapy; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers physical therapy, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for

subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

**STATEMENT OF EMERGENCY
907 KAR 8:030E**

This emergency administrative regulation is being promulgated in conjunction with six (6) other administrative regulations – 907 KAR 8:005E, Definitions for 907 KAR Chapter 8; 907 KAR 8:010E, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:015E, Independent occupational therapy service reimbursement provisions and requirements; 907 KAR 8:020E; Independent physical therapy service coverage provisions and requirements; 907 KAR 8:025E, Independent physical therapy service reimbursement provisions and requirements; and 907 KAR 8:035E, Independent speech pathology service reimbursement provisions and requirements – to expand the base of therapy service providers to ensure that Medicaid recipients have access to these services in accordance with federal requirements. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

**CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(New Emergency Administrative Regulation)**

907 KAR 8:030E. Independent speech pathology service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding speech pathology services provided by an independent speech-language pathologist.

Section 1. Provider Participation. (1) To be eligible to provide and be reimbursed for speech pathology services as an independent provider a provider shall be:

(a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

(c) A speech-language pathologist.

(2) In accordance with 907 KAR 17:010, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 2. Coverage and Limit. (1) The department shall reimburse for a speech pathology service if:

(a) The service:

1. Is provided:

a. By a speech-language pathologist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level;

3. Is prior authorized; and

4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by a speech-language pathologist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) speech pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each speech pathology service that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 3. No Duplication of Service. (1) The department shall not reimburse for a speech pathology service provided to a recipient by more than one (1) provider of any program in which speech pathology service is covered during the same time period.

(2) For example, if a recipient is receiving a speech pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the speech pathology service provided to the same recipient during the same time period via the home health program.

Section 4. Records Maintenance, Protection, and Security. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Chapter 164.

Section 5. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 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 8. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program coverage of speech pathology services provided by an independently enrolled speech-language pathologist. Currently, the Department for Medicaid Services (DMS) covers speech pathology services when provided in a physician's office (and the physician is the billing entity), when provided in an outpatient hospital (when the outpatient hospital is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for

individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This authorizes speech-language pathologists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for speech pathology services provided to Medicaid recipients. DMS is expanding the speech pathology services provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. Additionally, DMS anticipates many individuals who previously qualified for Medicaid benefits, but did not apply for benefits will seek benefits as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:035, Independent speech-pathology service reimbursement provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of speech pathology service providers in order to meet the demand for care (thus, to ensure recipient access to care.) The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Additionally, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any speech-language pathologist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for speech pathology services provided to Medicaid recipients. Additionally, Medicaid recipients in need of speech pathology services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many speech-language pathologists will choose to enroll in the Medicaid Program nor how many Medicaid recipients will receive services from independently enrolled speech-language pathologists.

(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 speech-language pathologist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the provider wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A speech-language pathologist who wishes to provide speech pathology services to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A speech-language pathologist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Medicaid recipients in need of speech pathology services will benefit from an expanded base of providers from which to receive speech pathology services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover speech pathology services; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers speech pathology services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

**STATEMENT OF EMERGENCY
907 KAR 8:035E**

This emergency administrative regulation is being promulgated in conjunction with six (6) other administrative regulations – 907 KAR 8:005E, Definitions for 907 KAR Chapter 8; 907 KAR 8:010E, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:015E, Independent occupational therapy service reimbursement provisions and requirements; 907 KAR 8:020E; Independent physical therapy service coverage provisions and requirements; 907 KAR 8:025E, Independent physical therapy service reimbursement provisions and requirements; and 907 KAR 8:030E, Independent speech pathology service coverage provisions and requirements – to expand the base of therapy service providers to ensure that Medicaid recipients have access to these services in accordance with federal requirements. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

**CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(New Emergency Administrative Regulation)**

907 KAR 8:035E. Speech pathology service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C).

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding speech language pathology services provided by an independent speech-language pathologist to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. For the department to reimburse for a speech language pathology service under this administrative regulation, the:

- (1) Speech-language pathologist shall meet the provider requirements established in 907 KAR 8:030; and
- (2) Speech language pathology service shall meet the coverage and related requirements established in 907 KAR 8:030.

Section 2. Reimbursement. The department shall reimburse for a speech language pathology service provided by a speech-language pathologist, in accordance with 907 KAR 8:030 and Section 2 of this administrative regulation, at 63.75 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

- (1) 907 KAR 8:030; and
- (2) This administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services

pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the reimbursement; and
- (2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding speech pathology services provided by an independently enrolled speech-language pathologist to Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for speech pathology services pursuant to this administrative regulation. Currently, the Department for Medicaid Services (DMS) covers speech pathology services when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in an outpatient hospital (billed by the outpatient hospital), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This administrative regulation authorizes speech-language pathologists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for speech pathology services provided to Medicaid recipients. DMS is expanding the speech pathology service provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. DMS must expand its provider base to meet the demand of the additional Medicaid recipients DMS anticipates beginning January 1, 2014 (in order to ensure recipient access to care.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:030, Independent speech pathology service coverage provisions and requirements and 907 KAR 8:005, Definitions for KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of speech pathology service providers in order to meet the demand for care (thus, to ensure recipient access to care.)

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any speech-language pathologist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for speech pathology services provided to Medicaid recipients. Additionally, Medicaid recipients in need of speech pathology services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many speech-language pathologists will choose to enroll in the Medicaid Program nor how many Medicaid recipients will receive services from independently enrolled speech-language pathologists.

(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 physical therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A physical therapist who wishes to provide speech pathology to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A speech-language pathologist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Medicaid recipients in need of speech pathology services will benefit from an expanded base of providers from which to receive speech pathology services

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover speech pathology; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers speech pathology services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY **907 KAR 10:014E**

This emergency administrative regulation is being promulgated to establish program integrity provisions and safeguards in order to ensure appropriate utilization of services and to adopt a uniform limit for physical therapy services and speech pathology services for Medicaid recipients in contrast to the current varied limits based on the individual's benefit plan. Additionally, the amended administrative regulation is being promulgated to establish that Medicaid Program coverage of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES **Department for Medicaid Services** **Division of Policy and Operations** **(Emergency Amendment)**

907 KAR 10:014E. Outpatient hospital service coverage provisions and requirements[service coverage].

RELATES TO: KRS 205.520, 42 C.F.R. 447.53

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6310, 205.8453

EFFECTIVE: December 26, 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 empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program service and coverage policies for outpatient hospital services[provisions relating to outpatient hospital services for which payment shall be made by the medical assistance program on behalf of the categorically needy and medically needy].

Section 1. Definitions. (1) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current

Procedural Terminology["Comprehensive choices" means a benefit plan for an individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022;

2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160;

4. The Model Waiver II Program in accordance with 907 KAR 1:595;

5. The Acquired Brain Injury Long Term Care Waiver Program in accordance with 907 KAR 3:210; or

6. The Michelle P. Waiver Program in accordance with 907 KAR 1:835; and

(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.]

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

(3) "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.

(4) "Emergency medical condition" is defined by 42 U.S.C. 1395dd(e)(1).

(5) "Enrollee" means a recipient who is enrolled with a managed care organization["Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to:

1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;

2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

6. 42 C.F.R. 457.310; and

(b) Has a designated package code of 2, 3, 4, or 5].

(6) "Federal financial participation" is defined by 42 C.F.R. 400.203["Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive K-TAP and are deprived due to death, incapacity, or absence;

2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or

3. Do not receive K-TAP and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. Receive SSP and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. SSP, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or

2. SSP, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits, are

eligible for "pass-through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(g) ~~Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass-through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022; or~~
(h) ~~Pregnant women~~].

(7) "Lock-in recipient" means a recipient enrolled in the department's lock-in program pursuant to 907 KAR 1:677.

(8) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53.

(10) "Provider" is defined by KRS 205.8451(7) ["Optimum choices" means a benefit plan for an individual who:

(a) ~~Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;~~

(b) ~~Receives services through either:~~

1. ~~An intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022; or~~

2. ~~The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and~~

(c) ~~Has a designated package code of S, T, U, V, W, X, Z, O, or 1].~~

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

(12) "Unlisted procedure or service" means a procedure;

(a) ~~For which there is not a specific CPT code; and~~

(b) ~~Which is billed using a CPT code designated for reporting unlisted procedures or services.~~

Section 2. Coverage Criteria. (1) To be covered by the department:

(a) The following~~[services]~~ shall be prior authorized and meet the requirements established in paragraph (b) of this subsection:

1. Magnetic resonance imaging~~[(MRI)];~~

2. Magnetic resonance angiogram~~[(MRA)];~~

3. Magnetic resonance spectroscopy;

4. Positron emission tomography~~[(PET)];~~

5. Cineradiography/videoradiography;

6. Xeroradiography;

7. Ultrasound subsequent to second obstetric ultrasound;

8. Myocardial imaging;

9. Cardiac blood pool imaging;

10. Radiopharmaceutical procedures;

11. Gastric restrictive surgery or gastric bypass surgery;

12. A procedure that is commonly performed for cosmetic purposes;

13. A surgical procedure that requires completion of a federal consent form; or

14. An unlisted procedure or service; and

(b) An outpatient hospital service, including those identified in paragraph (a) of this subsection, shall be:

1. ~~a.~~ Medically necessary; and

~~b.~~ 2. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and

2. ~~3.~~ For a lock-in recipient:

a. Provided by the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

b. A screening or emergency service that meets the requirements of subsection (6)(a) of this ~~section~~subsection.

(2) The prior authorization requirements established in subsection (1) of this section shall not apply to:

(a) An emergency service;

(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or

(c) A service provided to a recipient in an observation bed.

(3) A referring physician, a physician who wishes to provide a given service, or an advanced practice registered nurse may request prior authorization from the department.

(4) The following covered hospital outpatient services shall be furnished by or under the supervision of a duly licensed physician,

or if applicable, a duly-licensed dentist:

(a) A diagnostic service ordered by a physician;

(b) A therapeutic service, except for occupational therapy services as occupational therapy services shall not be covered under this administrative regulation, ordered by a physician;

(c) An emergency room service provided in an emergency situation as determined by a physician; or

(d) A drug, biological, or injection administered in the outpatient hospital setting.

(5) A covered hospital outpatient service for maternity care may be provided by:

(a) An advanced practice registered nurse~~[(APRN)]~~ who has been designated by the Kentucky Board of Nursing as a nurse midwife; or

(b) A registered nurse who holds a valid and effective permit to practice nurse midwifery issued by the Cabinet for Health and Family Services.

(6) The department shall cover:

(a) A screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; or

(b) An emergency service to a lock-in recipient if the department determines that the lock-in recipient had an emergency medical condition when the service was provided.

Section 3. Hospital Outpatient Services Not Covered by the Department. The following services shall not be considered a covered hospital outpatient service:

(1) An item or service that does not meet the requirements established in Section 2(1) of this administrative regulation;

(2) A service for which:

(a) An individual has no obligation to pay; and

(b) No other person has a legal obligation to pay;

(3) A medical supply or appliance, unless it is incidental to the performance of a procedure or service in the hospital outpatient department and included in the rate of payment established by the Medical Assistance Program for hospital outpatient services;

(4) A drug, biological, or injection purchased by or dispensed to a recipient~~[patient]~~;

(5) A routine physical examination;~~[or]~~

(6) A nonemergency service, other than a screening in accordance with Section 2(6)(a) of this administrative regulation, provided to a lock-in recipient:

1. In an emergency department of a hospital; or

2. If provided by a hospital that is not the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

(7) Occupational therapy services.

Section 4. Therapy Limits. (1) Speech language pathology services~~[therapy]~~ shall be limited to twenty (20) service~~]:~~

~~(a) Ten (10)] visits per calendar year per[twelve (12) months for a]~~ recipient~~[of the Global Choices benefit package; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit package; or~~

~~2. Optimum Choices benefit package].~~

(2) Physical therapy services shall be limited to twenty (20) service~~]:~~

~~(a) Fifteen (15)] visits per calendar year per[twelve (12) months for a]~~ recipient~~[of the Global Choices benefit package; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit package; or~~

~~2. Optimum Choices benefit package].~~

(3) A service in excess of the limits established in subsection (1) and (2) of this section shall be approved if the service in excess of the limits is determined to be medically necessary by the:

(a) Department if the recipient is not enrolled with a managed care organization; or

(b) Managed care organization in which the enrollee is enrolled if the recipient is an enrollee~~[The therapy limits established in subsections (1) and (2) of this section shall be over-ridden if the department determines that additional visits beyond the limit are medically necessary.~~

(a) To request an override:

1. The provider shall telephone or fax the request to the department; and

2. The department shall review the request in accordance with the provisions of 907 KAR 3:130 and notify the provider of its decision.

(b) An appeal of a denial regarding a requested override shall be in accordance with 907 KAR 1:563].

(4)[Except for recipients under age twenty-one (21),] Prior authorization by the department shall be required for each service visit that exceeds the limit established in subsections (1) and (2) of this section for a recipient who is not enrolled with a managed care organization[(5) The limits established in subsections (1) and (2) of this section shall not apply to a recipient under twenty-one (21) years of age].

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving speech therapy from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for speech therapy provided to the same recipient during the same time period via the outpatient hospital services program.

Section 6. Records Maintenance, Protection, and Security.

(1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Part 164.

Section 7. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 8. Third Party Liability. A provider shall comply with KRS 205.622.

Section 9. 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 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, or 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 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 10. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding outpatient hospital services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding outpatient hospital 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 Medicaid Program coverage provisions and requirements regarding outpatient hospital services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital 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 primary amendment sets a uniform limit [of twenty (20) physical therapy service visits or speech pathology service visits per recipient per calendar year] in lieu of the existing varied limits ranging from ten (10) to thirty (30) visits per recipient per month based on the benefit plan of the given recipient. The amendment preserves the existing option for recipients to receive

services above the limits if additional services are medically necessary and prior authorized. Additional amendments include deleting references to the four (4) Medicaid benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years; establishing that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to the same recipient by two (2) different providers at the same time; inserting records maintenance and relate confidentiality of medical records requirements; establishing that if third party liability exists for a given recipient that the provider is to bill the third party; establishing electronic signature requirements; and establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding; and inserting an appeals section for recipients regarding services being denied.

(b) The necessity of the amendment to this administrative regulation: Replacing the varying speech pathology service and physical therapy service limits with a uniform limit of twenty (20) service visits per recipient per calendar year is necessary to synchronize the Department for Medicaid Services' coverage of services with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year, DMS is adopting the same limit. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) Consequently, DMS is concurrently repealing the administrative regulation which establishes the four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years. The four (4) benefit plans vary little and DMS is establishing one (1) benefit plan for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. Additionally, there is an administrative and Medicaid Management Information System (MMIS) burden associated with preserving different plans as well as an administrative burden on providers and managed care organizations. Given that the plans vary little it is impractical if not inefficient to preserve the plans. The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided. Establishing an appeals section for recipients is necessary to reinforce that recipients have appeals' rights

regarding services being denied.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Outpatient hospitals will be affected by the amendment as will Medicaid recipients who receive physical therapy services or speech pathology services via the outpatient hospital program. Currently, there are 106 hospitals located in Kentucky and participating in the Medicaid Program. Over 20,000 Medicaid recipients received physical therapy services via the outpatient hospital program in the most recently completed state fiscal year. Over 4,300 Medicaid recipients received speech pathology services via the outpatient hospital program in the most recently completed state fiscal year.

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

(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 or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Outpatient hospitals will benefit from a simpler service limit structure as there will be one limit for all rather than variances due to four (4) different benefit plans.

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

(a) Initially: DMS cannot accurately predict the future utilization of outpatient hospital services, but in the most recently completed state fiscal year DMS spent approximately \$77 million (state and federal funds combined) on outpatient hospital services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent almost \$455.4 million (state and federal funds combined.) Of the nearly \$77 million spent by DMS on outpatient hospital services, over \$1.2 million (state and federal funds combined) was spent on physical therapy services; and over \$596,000 was spent on speech pathology services. Of the almost \$455.4 million spent by MCOs in aggregate on outpatient hospital services, almost \$6.9 million was spent on physical therapy services and over \$1.9 million was spent on speech pathology services.

(b) On a continuing basis: Please see the response to question (a).

(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 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: 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 the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.210 and 42 C.F.R. 440.220.

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. Medicaid programs are required to cover outpatient hospital services.

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? Some hospitals are owned by local government entities, but DMS is unable to accurately predict the impact of this amendment as revenues will depend on utilization of services. Given that more individuals will be eligible for Medicaid services (not as a result of the amendment to this administrative regulation though) utilization is expected to increase; thus, an increase in revenues is a logical expectation.

(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? Please see the response to question (b).

(c) How much will it cost to administer this program for the first year? DMS cannot accurately predict the future utilization of outpatient hospital services, but in the most recently completed state fiscal year DMS spent approximately \$77 million (state and federal funds combined) on outpatient hospital services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent almost \$455.4 million (state and federal funds combined.) Of the nearly \$77 million spent by DMS on outpatient hospital services, over \$1.2 million (state and federal funds combined) was spent on physical therapy services; and over \$596,000 was spent on speech pathology services. Of the almost \$455.4 million spent by MCOs in aggregate on outpatient hospital services, almost \$6.9 million was spent on physical therapy services and over \$1.9 million was spent on speech pathology services.

(d) How much will it cost to administer this program for subsequent years? Please see the response to question (c).

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY

907 KAR 13:005E

This emergency administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 13:010E, Private duty nursing service coverage provisions and requirements and 907 KAR 13:015E, Private duty nursing reimbursement provisions and requirements - to comply with an Affordable Care Act mandate. The three (3) administrative regulations are necessary to establish Kentucky Medicaid Program coverage and reimbursement of private duty nursing services. Private duty nursing services are a new benefit for Kentucky's Medicaid Program required as the benefit is covered in the "alternative benefit plan" adopted by Kentucky for Kentucky's Health Benefit (or Insurance) Exchange and for all Kentucky Medicaid recipients effective January 1, 2014. Additionally, the amended administrative regulation is being promulgated to establish that Medicaid Program reimbursement of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to comply with a federal mandate and to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Emergency Administrative Regulation)

907 KAR 13:005E. Definitions for 907 KAR Chapter 13.

RELATES TO: 194A.025(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

EFFECTIVE: December 26, 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 a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the definitions for 907 KAR Chapter 13.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designee.

(2) "Electronic signature" is defined by KRS 369.102(8).

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Home health agency" or "HHA" means a Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.

(5) "Immediate family member" is defined by KRS 205.8451(3).

(6) "Licensed practical nurse" is defined by KRS 314.011(9).

(7) "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.

(8) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Prior authorized" means authorized by:

(a) The department if the service is for a recipient who is not an enrollee; or

(b) A managed care organization if the service is for an enrollee.

(10) "Private duty nursing agency" means an agency licensed in accordance with 902 KAR 20:370.

(11) "Provider" is defined by KRS 205.8451(7).

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

(13) "Registered nurse" is defined by KRS 314.011(5).

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 201

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations located in 907 KAR Chapter 13 of the Kentucky Administrative Regulations. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing services. These are new services being covered by the Department for Medicaid Services (DMS) resulting from DMS's implementation of an alternative benefit plan (based on a "benchmark" or "benchmark equivalent plan") as required by the Affordable Care Act. Any state which expands its Medicaid eligibility groups to include the "expansion group" authorized by the Affordable Care Act is required to establish an alternative benefit plan for the expansion group. The expansion group is comprised primarily of adults under age sixty-five (65) who are not pregnant, who have income below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid benefits. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The benchmark plan or benchmark equivalent plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish a benchmark plan or benchmark equivalent plan for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to use the same "benchmark" or "benchmark equivalent plan" as the health benefit exchange to establish the alternative benefit plan for the Medicaid expansion group. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved

coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS's benefit plan will be the same for all Medicaid recipients – existing populations as well as new eligibility groups authorized or mandated by the Affordable Care Act. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: There are currently thirteen (13) private duty nursing agencies licensed in Kentucky and 109 home health agencies licensed 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. A private duty nursing agency that wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization. A home health agency that wishes to provide Medicaid-covered private duty nurse services must obtain a private duty nursing agency licensed from the Cabinet for Health and Family Services, Office of Inspector General in accordance with 902 KAR 20:370 and also enroll with the Medicaid Program as mentioned above for private duty nursing agencies.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A private duty nursing agency could experience administrative cost associated with enrolling in the Medicaid

Program. A home health agency which wishes to provide private duty nursing services could experience administrative costs associated with obtaining a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General as well as administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A private duty nursing agency that enrolls with the Medicaid Program and provide services to Medicaid recipients in accordance with this administrative regulation will benefit by being reimbursed for the services. Likewise, a home health agency that takes the requisite steps will benefit by being reimbursed by the Medicaid Program for private duty nursing services.

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

(a) Initially: Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(b) On a continuing basis: Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

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

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions for Medicaid private duty nursing services and reimbursement.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396u-7(b) establishes the federal mandate regarding the Medicaid Program's coverage of private duty nursing services; however, there is no federal mandate to define Medicaid terms in an administrative regulation.

2. State compliance standards. KRS 194A.030(2) states, "The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act."

3. Minimum or uniform standards contained in the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation and Medicaid programs are not required to cover private duty nursing services; however, any Medicaid program which adds, to its eligible population, the "expansion group" authorized by the Affordable Care Act, must establish an alternative benefit plan for the expansion group. The expansion group is a new eligibility category comprised of adults below age sixty-five (65), with income below 133% of the federal poverty level, who are not pregnant, and who do not otherwise qualify for Medicaid. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent package." There are four (4) acceptable such packages as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit package provided by the Federal Employees Health Benefit plan

Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit package the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The alternative benefit plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish an alternative benefit plan (plan of health care services covered) for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to have the same alternative benefit plan for the health benefit exchange as for the Medicaid expansion group. Kentucky selected an alternative benefit plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS is adopting the same benefit plan for all Medicaid recipients; thus, private duty nursing services will be covered for all Medicaid recipients who meet the coverage criteria. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation. As some home health agencies are owned by local governments, any such agency could be affected if it chooses to procure a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.80, 42 C.F.R. 440.330, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 is simply a definitions administrative regulation; however, the Department for Medicaid Services (DMS) is promulgating it in

conjunction with two (2) other administrative regulations related to private duty nursing services. - 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services. DMS's coverage of private duty nursing services could generate revenue for some local governments as there are home health agencies in Kentucky owned by a local government entity. If any such entity elected to obtain a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program the entity could receive revenues in the form of Medicaid reimbursement for private duty nursing services. The revenues are indeterminable as the Department for Medicaid Services cannot accurately predict how many such entities would take the requisite steps.

(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. The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.)

(d) How much will it cost to administer this program for subsequent years? Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its annual cost associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds) 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:

STATEMENT OF EMERGENCY 907 KAR 13:010E

This emergency administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 13:005E, Definitions for 907 KAR Chapter 13 and 907 KAR 13:015E, Private duty nursing service reimbursement provisions and requirements - to comply with an Affordable Care Act mandate. The three (3) administrative regulations are necessary to establish Kentucky Medicaid Program coverage and reimbursement of private duty nursing services. Private duty nursing services are a new benefit for Kentucky's Medicaid Program required as the benefit is covered in the "alternative benefit plan" adopted by Kentucky for Kentucky's Health Benefit (or Insurance) Exchange and for all Kentucky Medicaid recipients effective January 1, 2014. Additionally, the amended administrative regulation is being promulgated to establish that Medicaid Program reimbursement of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to comply with a federal mandate and to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (New Emergency Administrative Regulation)

907 KAR 13:010E. Private duty nursing service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.80, 440.330, and 42 U.S.C. 1396u-7

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding private duty nursing services.

Section 1. Provider Participation. (1) To be eligible to provide services under this administrative regulation, a provider shall be:

(a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in subsection (2) of this section, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

(c) 1. A private duty nursing agency; or

2. A home health agency licensed in accordance with 902 KAR 20:370 to provide private duty nursing services.

(2) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 2. Coverage and Limit. (1) The department shall reimburse for a private duty nursing service if the service is:

(a) Provided:

1. By a:

a. Registered nurse employed by a:

(i) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section 3 of this administrative regulation; or

b. Licensed practical nurse employed by a:

(i) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section 3 of this administrative regulation;

2. To a recipient in the recipient's home, except as provided in subsection (2) of this section; and

3. Under the direction of the recipient's physician in accordance with 42 C.F.R. 440.80;

(b) 1. Prescribed for the recipient by a physician; and

2. Stated in the recipient's plan of treatment developed by the prescribing physician;

(c) Established as being needed for the recipient in the recipient's home;

(d) Prior authorized; and

(e) Medically necessary.

(2) A private duty nursing service may be covered in a setting other than in the recipient's home, if the service is provided during a normal life activity of the recipient that requires the recipient to be out of his or her home.

(3)(a) There shall be an annual limit of private duty nursing services per recipient of 2,000 hours.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limit are determined to be medically necessary.

Section 3. No Duplication of Service. The department shall not reimburse for any of the following services providing during the same time that a private duty nursing service is provided to a recipient:

- (1) A personal care service;
- (2) A skilled nursing service or visit; or
- (3) A home health aide service.

Section 4. Conflict of Interest. The department shall not reimburse for a private duty nursing service provided to a recipient if the individual providing the service is:

- (1) An immediate family member of the recipient; or
- (2) A legally responsible individual who maintains his or her primary residence with the recipient.

Section 5. Records Maintenance, Protection, and Security.

(1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) A provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service.

(b) If the United States Department of Health and Human Services secretary requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Part 164.

Section 6. Medicaid Program Participation Compliance. (1) A provider shall comply with:

- (a) 907 KAR 1:671;
- (b) 907 KAR 1:672; and
- (c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

Section 7. Third Party Liability. A provider shall comply with KRS 205.622.

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 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, or 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. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 10. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 11. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program private duty nursing services. These are new services being covered by the Department for Medicaid Services (DMS) resulting from DMS's implementation of an alternative benefit plan (based on a "benchmark" or "benchmark equivalent plan") as required by the Affordable Care Act. Any state which expands its Medicaid eligibility groups to include the "expansion group" authorized by the Affordable Care Act is required to establish an alternative benefit plan for the expansion group. The expansion group is comprised primarily of adults under age sixty-five (65) who are not pregnant, who have income below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid benefits. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees;

The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The benchmark plan or benchmark equivalent plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish a benchmark plan or benchmark equivalent plan for its health benefit exchange. States who add the Medicaid

expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to use the same "benchmark" or "benchmark equivalent plan" as the health benefit exchange to establish the alternative benefit plan for the Medicaid expansion group. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS's benefit plan will be the same for all Medicaid recipients – existing populations as well as new eligibility groups authorized or mandated by the Affordable Care Act. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: There are currently thirteen (13) private duty nursing agencies licensed in Kentucky and 109 home health agencies licensed 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. A private duty nursing agency that wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization. A home health agency that wishes to provide Medicaid-covered private duty nurse services must obtain a private duty nursing agency licensed from the Cabinet for Health and Family Services, Office of Inspector General in accordance with 902 KAR 20:370 and also enroll with

the Medicaid Program as mentioned above for private duty nursing agencies.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A private duty nursing agency could experience administrative cost associated with enrolling in the Medicaid Program. A home health agency which wishes to provide private duty nursing services could experience administrative costs associated with obtaining a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General as well as administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A private duty nursing agency that enrolls with the Medicaid Program and provide services to Medicaid recipients in accordance with this administrative regulation will benefit by being reimbursed for the services. Likewise, a home health agency that takes the requisite steps will benefit by being reimbursed by the Medicaid Program for private duty nursing services.

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

(a) Initially: DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396u-7(b).

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. Medicaid programs are not required to cover private duty nursing services; however, any Medicaid program which adds, to its eligible population, the "expansion group" authorized by the Affordable Care Act, must establish an alternative benefit plan for the expansion group. The expansion group is a new eligibility category comprised of adults below age sixty-five (65), with income below 133% of the federal poverty level, who are not pregnant, and who do not otherwise qualify for Medicaid. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent package." There are four (4) acceptable such packages as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit package provided by the Federal

Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit package the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The alternative benefit plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish an alternative benefit plan (plan of health care services covered) for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to have the same alternative benefit plan for the health benefit exchange as for the Medicaid expansion group. Kentucky selected an alternative benefit plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS is adopting the same benefit plan for all Medicaid recipients; thus, private duty nursing services will be covered for all Medicaid recipients who meet the coverage criteria.

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 the amendment to this administrative regulation. As some home health agencies are owned by local governments, any such agency could be affected if it chooses to procure a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.80, 42 C.F.R. 440.330, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 could generate revenue for some local governments as there are home health agencies in Kentucky owned by a local government entity. If any such entity elected to obtain a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program the entity could receive revenues in the form

of Medicaid reimbursement for private duty nursing services. The revenues are indeterminable as the Department for Medicaid Services cannot accurately predict how many such entities would take the requisite steps.

(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. The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 13:015E

This emergency administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 13:005E, Definitions for 907 KAR Chapter 13 and 907 KAR 13:010E, Private duty nursing service coverage provisions and requirements - to comply with an Affordable Care Act mandate. The three (3) administrative regulations are necessary to establish Kentucky Medicaid Program coverage and reimbursement of private duty nursing services. Private duty nursing services are a new benefit for Kentucky's Medicaid Program required as the benefit is covered in the "alternative benefit plan" adopted by Kentucky for Kentucky's Health Benefit (or Insurance) Exchange and for all Kentucky Medicaid recipients effective January 1, 2014. Additionally, the amended administrative regulation is being promulgated to establish that Medicaid Program reimbursement of the services under this administrative regulation is contingent upon the receipt of federal approval and federal funding in order to prevent expending Kentucky taxpayer funds when federal matching funds are not provided. This action must be taken on an emergency basis to comply with a federal mandate and to prevent a potential loss of state funds. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (New Emergency Administrative Regulation)

907 KAR 13:015E. Private duty nursing service reimbursement provisions and requirements.

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

EFFECTIVE: December 26, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding private duty nursing services.

Section 1. General Requirements. For the department to reimburse for a private duty nursing service under this administrative regulation, the:

(1) Provider shall meet the provider requirements established in 907 KAR 13:010; and

(2) The service shall meet the coverage and related requirements established in 907 KAR 13:010.

Section 2. Reimbursement. The department shall:

(1) Reimburse for private duty nursing services at a rate of nine (9) dollars per fifteen (15) minutes; and

(2) Not reimburse for more than:

(a) Ninety-six (96) units per recipient per twenty-four (24) hour period; or

(b) 8,000 units per twelve (12) consecutive month period per recipient.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for a service covered pursuant to 907 KAR 13:010 and this administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding private duty nursing services. These are new services being covered by the Department for Medicaid Services (DMS) resulting from DMS's implementation of an alternative benefit plan (based on a "benchmark" or "benchmark equivalent plan") as required by the Affordable Care Act. Any state which expands its Medicaid eligibility groups to include the "expansion group" authorized by the Affordable Care Act is required to establish an alternative benefit plan for the expansion group. The expansion group is comprised primarily of adults under age sixty-five (65) who are not pregnant, who have income below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid benefits. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health

coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The benchmark plan or benchmark equivalent plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish a benchmark plan or benchmark equivalent plan for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to use the same "benchmark" or "benchmark equivalent plan" as the health benefit exchange to establish the alternative benefit plan for the Medicaid expansion group. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS's benefit plan will be the same for all Medicaid recipients – existing populations as well as new eligibility groups authorized or mandated by the Affordable Care Act. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services. DMS will reimburse for private duty nursing services at a rate of nine (9) dollars per fifteen (15) minute unit and services will be limited to no more than ninety-six (96) units per twenty-four (24) hour period and 8,000 units per twelve (12) consecutive months.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish reimbursement for private duty nursing services which are being added to DMS's array of covered services via companion administrative regulations - 907 KAR 13:005, Definitions for 907 KAR Chapter 13 and 907 KAR 13:010, Private duty nursing service coverage provisions and requirements. DMS is adding private duty nursing services to its scope of covered services as explained in paragraph (a) above.

(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 complying with the Affordable Care Act.

(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 complying with the Affordable Care Act.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: There are currently thirteen (13) private duty nursing agencies licensed in Kentucky and 109 home health agencies licensed 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. A private duty nursing agency that wishes to provide services to Medicaid recipients and be reimbursed by DMS for the services will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization. A home health agency that wishes to provide Medicaid-covered private duty nurse services must obtain a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General in accordance with 902 KAR 20:370 and also enroll with the Medicaid Program as mentioned above for private duty nursing agencies.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A private duty nursing agency could experience administrative cost associated with enrolling in the Medicaid Program. A home health agency which wishes to provide private duty nursing services could experience administrative costs associated with obtaining a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General as well as administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A private duty nursing agency that enrolls with the Medicaid Program and provide services to Medicaid recipients in accordance with this pursuant to this administrative regulation. DMS is establishing a rate of nine (9) dollars per fifteen (15) minute unit for private duty nursing services. Likewise, a home health agency that takes the requisite steps will benefit by being reimbursed by the Medicaid Program for private duty nursing services at the aforementioned rate.

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

(a) Initially: DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396u-7(b), 42 U.S.C. 1396a(a)(30), and 42 C.F.R. 447.204.

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. Medicaid programs are not required to cover private duty nursing services; however, any Medicaid program which adds, to its eligible population, the "expansion group" authorized by the Affordable Care Act, must establish an alternative benefit plan for the expansion group. The expansion group is a new eligibility category comprised of adults below age sixty-five (65), with income below 133 percent of the federal poverty level, who are not pregnant, and who do not otherwise qualify for Medicaid. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent package." There are four (4) acceptable such packages as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit package provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit package the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The alternative benefit plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish an alternative benefit plan (plan of health care services covered) for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to have the same alternative benefit plan for the health benefit exchange as for the Medicaid expansion group. Kentucky selected an alternative benefit plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS is adopting the same benefit plan for all Medicaid recipients; thus, private duty nursing services will be covered for all Medicaid recipients who meet the coverage criteria. 42 U.S.C. 1396a(a)(30) requires Medicaid program payments to be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the same geographic area. 42 C.F.R. 447.204 requires Medicaid reimbursement to be sufficient to enlist enough providers to ensure that services are available to Medicaid recipients at least to the extent that they are available to the general population.

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 the amendment to this administrative regulation. As some home health agencies are owned by local governments, any such agency could be affected if it chooses to procure a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.80, 42 C.F.R. 440.330, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 could generate revenue for some local governments as there are home health agencies in Kentucky owned by a local government entity. If any such entity elected to obtain a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program the entity could receive revenues in the form of Medicaid reimbursement for private duty nursing services. The revenues are indeterminable as the Department for Medicaid Services cannot accurately predict how many such entities would take the requisite steps.

(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. The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

STATEMENT OF EMERGENCY 907 KAR 15:005E

This emergency administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 15:010E, Coverage provisions and requirements regarding behavioral health services provided by independent providers, and 907 KAR 15:015E, Reimbursement provisions and requirements regarding behavioral health services provided by independent providers - to comply with an Affordable Care Act mandate. The three (3) administrative regulations are necessary to establish

Kentucky Medicaid Program coverage and reimbursement of additional behavioral health services including substance use disorder services. The Department for Medicaid Services (DMS) currently covers substance use related services for pregnant women and children; however, the Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria.) Additionally, DMS is expanding the base of behavioral health providers to ensure that there is an adequate supply of providers to meet Medicaid recipient demand for care – as federally required. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Commissioner's Office (New Emergency Administrative Regulation)

907 KAR 15:005E. Definitions for 907 KAR Chapter 15.

RELATES TO: 194A.025(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

EFFECTIVE: December 30, 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 a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the definitions for 907 KAR Chapter 15.

Section 1. Definitions. (1) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(2) "Billing provider" means the individual or entity who:

(a) Is authorized to bill the department or a managed care organization for a service; and

(b) Is eligible to be reimbursed by the department or a managed care organization for a service.

(3) "Certified social worker" means an individual who:

(a) Meets the requirements established in KRS 335.080; and

(b) Has at least a master's degree in social work.

(4) "Community support associate" means an individual who meets the community support associate requirements established in 908 KAR 2:250.

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

(6) "Electronic signature" is defined by KRS 369.102(8).

(7) "Enrollee" means a recipient who is enrolled with a managed care organization.

(8) "Face-to-face" means occurring:

(a) In person; or

(b) Via a real-time, electronic communication that involves two (2)-way interactive video and audio communication.

(9) "Family peer support specialist" means an individual who meets the requirements for a Kentucky family peer support specialist established in 908 KAR 2:230.

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

(11) "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(12) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(13) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(14) "Licensed professional counselor associate" is defined by KRS 335.500(3).

(15) "Licensed psychological associate" means an individual who:

(a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.

(16) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(17) "Licensed psychologist" means an individual who:

(a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

(18) "Managed care organization" 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.

(19) "Marriage and family therapy associate" is defined by KRS 335.300(3).

(20) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(21) "Peer support specialist" means an individual who meets the peer specialist qualifications established in 908 KAR 2:220.

(22) "Physician" is defined by KRS 205.510(11) and 42 C.F.R. 405.2401(b).

(23) "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(24) "Provider" is defined by KRS 205.8451(7).

(25) "Provider abuse" is defined by KRS 205.8451(8).

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

(27) "Recipient abuse" is defined by KRS 205.8451(10).

(28) "Registered nurse" is defined by KRS 314.011(5).

(29) "Youth peer support specialist" means an individual who meets the requirements established for a Kentucky youth peer support specialist established in 908 KAR 2:240.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independently enrolled providers (such as a licensed psychologist, licensed professional clinical counselor, licensed clinical social worker, licensed psychological practitioner, licensed marriage and family therapist) rather than agency behavioral health service providers (such as a community mental health center, federally qualified health center, or rural health clinic.)

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independent providers. The Department for Medicaid Services (DMS) is expanding its scope of behavioral health service coverage to include substance use disorder services as a result of an Affordable Care Act mandate for Medicaid programs to cover such services for all Medicaid recipients. Currently, DMS covers such services for pregnant women and

children.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independent providers.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independent providers.

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

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients of behavioral health services (including substance use disorder services) and independent behavioral health service providers (including substance use disorder service providers) will be affected by the administrative regulation.

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

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

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals will benefit due to terms being defined.

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

(a) Initially: No cost is necessary to initially implement this administrative regulation.

(b) On a continuing basis: No continuing cost is necessary to implement this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

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

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions for Medicaid independent behavioral health services (including

substance use disorder services) and reimbursement.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

2. State compliance standards. KRS 194A.030(2) states, "The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act."

3. Minimum or uniform standards contained in the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation; however, Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

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? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this administrative regulation in the first year.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary in subsequent years to

implement this administrative regulation.

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

Revenues (+/-): .

Expenditures (+/-):

Other explanation:

STATEMENT OF EMERGENCY

907 KAR 15:010E

This emergency administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 15:005E, Definitions for 907 KAR Chapter 15, and 907 KAR 15:015E, Reimbursement provisions and requirements regarding behavioral health services provided by independent providers - to comply with an Affordable Care Act mandate. The three (3) administrative regulations are necessary to establish Kentucky Medicaid Program coverage and reimbursement of additional behavioral health services including substance use disorder services. The Department for Medicaid Services (DMS) currently covers substance use related services for pregnant women and children; however, the Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria.) Additionally, DMS is expanding the base of behavioral health providers to ensure that there is an adequate supply of providers to meet Medicaid recipient demand for care – as federally required. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor

AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Emergency Administrative Regulation)

907 KAR 15:010E. Coverage provisions and requirements regarding behavioral health services provided by independent providers.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

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

EFFECTIVE: December 30, 2013

NECESSITY, FUNCTION, AND CONFORMITY: KRS 65A.020(3)(a) requires the Department for Local Government to promulgate administrative regulations to develop standard forms, protocols, timeframes, and due dates for the submission of information by special purpose governmental entities. This administrative regulation establishes the format for financial disclosure by special purpose governmental entities and prescribes the protocols, timeframes, and due dates for submission of information by special purpose governmental entities.

Section 1. Definitions. (1) "Annual revenue" means all revenue, from whatever source, received by the special purpose governmental entity during the most recent fiscal period for which data is available, as reflected in the budget to actual portion of DLG Form SPGE 101 required by Section 4(1) of this administrative regulation.

(2) "Budget" means the estimated revenues and appropriations for a fiscal period.

(3) "DLG" is defined by KRS 65A.010(2).

(4) "Fiscal period" means the fiscal year adopted by the special purpose governmental entity for budgeting purposes.

(5) "Registry" is defined by KRS 65A.010(7).

(6) "Special purpose governmental entity" or "SPGE" is defined by KRS 65A.010(8).

Section 2. Registration with the Department for Local Government. (1) All Special Purpose Governmental Entities in existence prior to December 31, 2013 shall, prior to December 31, 2013, complete and submit DLG Form SPGE 100 Special Purpose Governmental Entity Registration and Board Reporting Form. The information shall be submitted in the same manner as required by Section 3(1) of this administrative regulation. The DLG may allow an alternative form of submission as provided in Section 3(2) of this administrative regulation. This submission shall serve as the initial registration required by KRS 65A.090(1).

(2) A special purpose governmental entity established after December 31, 2013 shall complete and submit DLG Form SPGE 100 Special Purpose Governmental Entity Registration and Board Reporting Form within fifteen (15) days of the establishment of the entity. The form shall be submitted as provided in subsection (1) of this section.

Section 3. Electronic submission required; exceptions. (1) Except as provided by subsections (2) and (3) of this section, all information required to be submitted to the DLG shall be submitted electronically, using the information reporting portal on the DLG Web site at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm>.

(2) A special purpose governmental entity may request approval from the DLG to submit required information by alternative means. The request shall be in writing, and shall:

(a) State the name of the special purpose governmental entity;

(b) List all information for which an alternative means of submission is sought;

(c) Be made by the governing body of the special purpose governmental entity;

(d) Be received by the DLG at least sixty (60) days before the information to which the request relates is due;

(e) State the reason why the required information cannot be submitted using the standard electronic submission format; and

(f) Identify the method of submission proposed.

(3)(a) Approval of an alternative submission method shall be at the discretion of the DLG. If the DLG approves an alternative submission method, the special purpose governmental entity shall submit the information in the form and format determined by the DLG and communicated to the special purpose governmental entity as part of the approval process.

(b) The DLG may withdraw approval to use an alternative reporting method at any time by providing written notice of the withdrawal of approval to the special purpose governmental entity at least thirty (30) days prior to the effective date of the withdrawal of approval.

Section 4. Requirements for Submission of Administrative and Financial Information. For each fiscal period beginning on or after July 1, 2014, each special purpose governmental entity shall annually submit information for publication on the registry as required by this section. (1) Within fifteen (15) days following the beginning of each fiscal period, the SPGE shall submit the administrative information required by KRS 65A.020(2)(a)1, using Section I of DLG Form SPGE 101.

(2) The SPGE shall submit the budget information required by KRS 65A.020(2)(a)1 using DLG Form SPGE 101 and shall submit the budget information as required by this subsection.

(a) Each special purpose governmental entity shall submit its adopted budget to the DLG within fifteen (15) days following the beginning of the fiscal period for which the adopted budget applies.

(b) Each special purpose governmental entity shall submit a comparison of the adopted budget to actual revenues and expenditures for each fiscal period within sixty (60) days following the close of each fiscal period.

(c) The comparison of the adopted budget to actual revenues and expenditures shall be reflected on the budget to actual portion of SPGE 101.

(3) Within fifteen (15) days following the beginning of each

fiscal period, each SPGE shall submit the financial information required by KRS 65A.020(2)(a)2. This information shall be submitted using DLG Form SPGE 101 and shall list all taxes, fees, or charges imposed and collected by the entity, including the rates or amounts charged for the reporting period and the statutory authority for the levy of the tax, fee, or charge.

Section 5. Submission of Audits and Attestation Engagements.

(1) An audit or attestation engagement required to be submitted for publication on the registry pursuant to KRS 65A.030 shall be submitted to the DLG within fifteen (15) days following receipt of the completed audit or attestation engagement by the special purpose governmental entity.

(2)(a) A special purpose governmental entity required by KRS 65A.030(1)(a)(2) to contract for the provision of an attestation engagement shall ensure that it receives the attestation engagement no later than July 1, 2018, or, for attestation engagements required by KRS 65A.030(1)(a)(2) after July 1, 2018, no more than four (4) years from the date of the special purpose governmental entity's last attestation engagement.

(b) A special purpose governmental entity required by KRS 65A.030(1)(b)(2) to contract for the provision of an independent audit shall ensure that it receives the independent audit no later than July 1, 2018, or, for independent audits required by KRS 65A.030(1)(b)(2) after July 1, 2018, no more than four (4) years from the date of either:

1. The entity's last independent audit, or

2. The date the entity first reported to the DLG annual receipts from all sources or annual expenditures equal to or greater than \$100,000 but less than \$500,000.

(c) A special purpose governmental entity required by KRS 65A.030(1)(c)(2) to contract for the provision of an annual audit shall ensure that it receives an audit no more than one (1) year from the date it last reported to the DLG annual receipts from all sources or annual expenditures equal to or greater than \$500,000.

(3) Each submission shall be submitted to the DLG website as a portable document format (PDF) file.

(4) Except as provided in subsection (5) of this section, an audit shall be conducted on a modified cash basis of accounting as described in this subsection.

(a) Revenues shall be recognized when received;

(b) Expenditures shall be recognized when paid;

(c) Capital assets and long-term debt shall be reported when material to the special purpose governmental entity;

(d) Note disclosures shall include all those required by generally accepted accounting principles to the extent those disclosures apply to the special purpose governmental entity under the modified cash basis of accounting described in this subsection; and

(e) Cash and other liquid assets available that are held in reserve for future purposes shall be disclosed.

(5) As an alternative to the minimum requirements established in subsection (3) of this section, an audit may be conducted under generally accepted accounting principles.

Section 6. Payment of the Registration Fee. (1) Each special purpose governmental entity shall pay the annual registration fee required by KRS 65A.020(5) within fifteen (15) days after the start of each fiscal period.

(a) The amount paid by each special purpose governmental entity shall be based on annual revenues of the special purpose governmental entity. For each fiscal period for which a registration fee is due, if the annual revenue information has not been submitted to the DLG as required by Section 4(3) of this administrative regulation, the annual revenues on which the registration fee shall be based shall be the annual revenues reported as part of the initial registration of the special purpose governmental entity pursuant to KRS 65A.090.

(b) Payment shall be made electronically, using the information reporting portal on the DLG Web site, at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm> unless permission to pay by an alternative method has been granted under subsections (2) and (3) of this section.

(c) Payment shall be accompanied by a completed DLG Form SPGE 101.

(2) A special purpose governmental entity may request permission to pay the registration fee by alternative means by submitting a written request that includes the following information at least thirty (30) days before the payment is due:

(a) The name of the special purpose governmental entity;

(b) A statement of the reason why the payment cannot be submitted using the standard electronic submission format; and

(c) The method of payment proposed.

(3)(a) Approval of an alternative method of payment shall be at the discretion of the DLG. If the DLG approves an alternative payment method, the special purpose governmental entity shall submit the payment in the form and format determined by the DLG and communicated to the special purpose governmental entity as part of the approval process.

(b) The DLG may withdraw approval to use an alternative payment method at any time by providing written notice of the withdrawal of approval to the special purpose governmental entity at least thirty (30) days prior to the effective date of the withdrawal of approval.

Section 7. Failure to File Required Information or to Pay the Annual Registration Fee in a Timely Manner. Any special purpose governmental entity that fails to file a report or form in the form and format and within the timeframes required by this administrative regulation, or that fails to submit payment of the annual registration fee as required by this administrative regulation, shall be subject to the provisions of KRS 65A.040.

Section 8. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) DLG Form SPGE 100, "Special Purpose Governmental Entity (SPGE) Registration and Board Reporting Form", September 2013; and

(b) DLG Form SPGE 101, "Special Purpose Governmental Entity (SPGE) Financial Disclosure Report", September 2013.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Local Government, 1024 Capital Center Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or online at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm>.

TONY WILDER, Commissioner

APPROVED BY AGENCY: December 6, 2013

FILED WITH LRC: December 18, 2013 at 4 p.m.

CONTACT PERSON: Darren T. Sammons, Staff Attorney, Department for Local Government, 1024 Capital Center Drive, Suite 341, Frankfort, Kentucky 40601, phone (502) 573-2382, fax (502) 573-2939.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Darren T. Sammons

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation prescribes and adopts the standard forms, protocols, timeframes, and due dates for the submission of information by special purpose governmental entities. This administrative regulation establishes the format for financial disclosure by special purpose governmental entities and prescribes the protocols, timeframes, and due dates for submission of information by special purpose governmental entities.

(b) The necessity of this administrative regulation: This administrative regulation is necessary for DLG to satisfy the requirements of KRS Chapter 65A.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms closely to the content of KRS Chapter 65A by establishing the manner in which special purpose governmental entities will register with DLG and submit the administrative and financial information required by statute. This administrative regulation imposes no additional requirements beyond those set forth by the statute or

which DLG concludes are required by implication or otherwise are necessary for the statute to be effective.

(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 statute primarily by setting forth the mechanism by which special purpose governmental entities will report administrative and financial information and by prescribing the method by which such entities will pay the statutory fees.

(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: Not applicable.

(b) The necessity of the amendment to this administrative regulation: Not applicable.

(c) How the amendment conforms to the content of the authorizing statutes: Not applicable.

(d) How the amendment will assist in the effective administration of the statutes: Not applicable.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects entities that meet the definition of Special Purpose Governmental Entities as defined by KRS 65A.010. At present, DLG is aware of 1,272 entities that meet the statutory definition.

(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 regulated entities will have to file administrative and financial information with the Department for Local Government and will have to pay the statutory filing fee.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each entity will have to pay twenty-five (25) dollars, \$250 or \$500, as required by KRS 65A.020(5)(b).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The financial information for each special purpose governmental entity will be reported and published in an electronic format that will be accessible to all members of the public. Such greater transparency may increase public confidence in special purpose governmental entities.

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

(a) Initially: \$63,700, which has been provided as a Necessary Governmental Expense ("NGE").

(b) On a continuing basis: The statutory fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) years.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Funding has been provided as a Necessary Governmental Expense ("NGE") by the General Assembly.

(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 will be necessary to implement the administrative regulation. The fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) years.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation does not establish any fees, however, it does specify the method for payment of the fees that were established by KRS 65A.020(5)(b).

(9) TIERING: Is tiering applied? The fees were established by KRS 65A.020(5)(b), which applies tiering as follows: "Special Purpose Governmental Entities with an annual revenue from all

sources of less than \$100,000, twenty-five (25) dollars;" "Special Purpose Governmental Entities with an annual revenue from all sources of at least \$100,000 but less than \$500,000, \$250;" and "Special Purpose Governmental Entities with an annual revenues of \$500,000 or greater, \$500."

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 Special Purpose Governmental Entities, as defined by KRS 65A.010(8), will be impacted by this regulation.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 65A.020, 65A.030, 65A.040, and 65A.090

(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 will have no effect on the expenditures and revenues of any state or local government agency. However, there may be an effect from the authorizing statute (KRS Chapter 65A).

(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 any state or local government agency. However, there may be revenue from the authorizing statute (KRS Chapter 65A), but any revenue is expected to cover the expense of the program itself.

(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 any state or local government agency. However, there may be revenue from the authorizing statute (KRS Chapter 65A), but any revenue is expected to cover the expense of the program itself.

(c) How much will it cost to administer this program for the first year? This program will cost an estimated \$63,700.

(d) How much will it cost to administer this program for subsequent years? The statutory fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) 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: No additional expenditures are necessary to implement this administrative regulation.

STATEMENT OF EMERGENCY 907 KAR 15:015E

This emergency administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 15:005E, Definitions for 907 KAR Chapter 15, and 907 KAR 15:010E, Coverage provisions and requirements regarding behavioral health services provided by independent providers - to comply with an Affordable Care Act mandate. The three (3) administrative regulations are necessary to establish Kentucky Medicaid Program coverage and reimbursement of additional behavioral health services including substance use disorder services. The Department for Medicaid Services (DMS) currently covers substance use related services for pregnant women and children; however, the Affordable Care Act mandates coverage of substance use disorder services for all Medicaid recipients (who meet qualifying criteria.) Additionally, DMS is expanding the base of behavioral health providers to ensure that there is an adequate supply of providers to meet Medicaid recipient demand for care –

as federally required. This action must be taken on an emergency basis to comply with a federal mandate. This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler. The ordinary administrative regulation is identical to this emergency administrative regulation.

STEVEN L. BESHEAR, Governor
AUDREY TAYSE HAYNES, Secretary

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Division of Policy and Operations (New Emergency Administrative Regulation)

907 KAR 15:015E. Reimbursement provisions and requirements for behavioral health services provided by independent providers.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

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

EFFECTIVE: December 20, 2013

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program as Medicaid providers, or behavioral health service practitioners working for or under supervision of the independent behavioral health service providers, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. For the department to reimburse for a service covered under this administrative regulation, the service shall be:

- (1) Medically necessary;
- (2) Provided:
 - (a) To a recipient; and
 - (b) By a:
 1. Provider who meets the provider participation requirements established in 907 KAR 15:010; or
 2. Practitioner working under the supervision of a provider who meets the provider participation requirements established in 907 KAR 15:010;
- (3) A service covered in accordance with 907 KAR 15:010; and
- (4) Billed to the department by the billing provider who provided the service or under whose supervision the service was provided by an authorized practitioner in accordance with 907 KAR 15:010.

Section 2. Reimbursement. (1) One (1) unit of service shall be fifteen (15) minutes in length or the unit amount identified in the corresponding current procedural terminology code.

(2) The rate per unit for a screening shall be:

- (a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Physician; or
 2. Psychiatrist;
- (b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:
 1. An advanced practice registered nurse; or
 2. A licensed psychologist;
- (c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Licensed professional clinical counselor;

2. Licensed clinical social worker;
 3. Licensed psychological practitioner; or
 4. Licensed marriage and family therapist; or
 (d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;
 2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
 3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
 4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or
 5. Physician assistant working for a physician if the physician is the billing provider for the service.
 (3) The rate per unit for an assessment shall be:
 (a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Physician; or
 2. Psychiatrist;
 (b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:
 1. An advanced practice registered nurse; or
 2. A licensed psychologist;
 (c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Licensed professional clinical counselor;
 2. Licensed clinical social worker;
 3. Licensed psychological practitioner; or
 4. Licensed marriage and family therapist; or
 (d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;
 2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
 3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
 4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or
 5. Physician assistant working for a physician if the physician is the billing provider for the service.
 (4) The rate per unit for psychological testing shall be:
 (a) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychologist;
 (b) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychological practitioner; or
 (c) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service.
 (5) The rate per unit for screening, brief intervention, and referral to treatment shall be:
 (a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if

provided by a:
 1. Physician; or
 2. Psychiatrist;
 (b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:
 1. An advanced practice registered nurse; or
 2. A licensed psychologist;
 (c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Licensed professional clinical counselor;
 2. Licensed clinical social worker;
 3. Licensed psychological practitioner; or
 4. Licensed marriage and family therapist; or
 (d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;
 2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
 3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
 4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or
 5. Physician assistant working for a physician if the physician is the billing provider for the service.
 (6) The rate per unit for crisis intervention shall be:
 (a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Physician; or
 2. Psychiatrist;
 (b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:
 1. An advanced practice registered nurse; or
 2. A licensed psychologist;
 (c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Licensed professional clinical counselor;
 2. Licensed clinical social worker;
 3. Licensed psychological practitioner; or
 4. Licensed marriage and family therapist; or
 (d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:
 1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;
 2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;
 3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;
 4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;
 5. Physician assistant working for a physician if the physician is the billing provider for the service;
 6. Peer support specialist working under the supervision of a mental health professional;
 7. Family peer support specialist working under the supervision of a mental health professional; or
 8. Youth peer support specialist working under the supervision of a mental health professional.

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or
2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;
2. Licensed clinical social worker;
3. Licensed psychological practitioner; or
4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(12) The rate per unit for medication assisted treatment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or
2. Psychiatrist; or

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by an advanced practice registered nurse.

(13) The rate per unit for day treatment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or
2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or
2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;
2. Licensed clinical social worker;
3. Licensed psychological practitioner; or
4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is

the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health professional.

(14) The rate per unit for comprehensive community support services shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or
2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or
2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;
2. Licensed clinical social worker;
3. Licensed psychological practitioner; or
4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health professional.

(15) The rate per unit for peer support services shall be fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

(a) Peer support specialist working under the supervision of a mental health professional;

(b) Family peer support specialist working under the supervision of a mental health professional; or

(c) Youth peer support specialist working under the supervision of a mental health professional.

(16) The rate per unit for parent or family peer support services shall be fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

(a) Peer support specialist working under the supervision of a mental health professional;

(b) Family peer support specialist working under the supervision of a mental health professional; or

(c) Youth peer support specialist working under the supervision of a mental health professional.

(17) The department shall not reimburse for a service billed by or on behalf of an entity or individual that is not a billing provider.

Section 3. No Duplication of Service. (1) The department shall

not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independent behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a community mental health center.

Section 4. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

- (1) 907 KAR 15:010; and
- (2) This administrative regulation.

Section 5. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the reimbursement; and
- (2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

- (1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the reimbursement provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program as Medicaid providers, or behavioral health service practitioners working under for or under supervision of the independent behavioral health service providers, to Medicaid recipients who are not enrolled with a managed care organization. This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 15:010 (Provisions and requirements regarding behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for KAR Chapter 15). Currently, the Department for Medicaid Services does not enroll licensed psychologists, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, or licensed psychological practitioners as independent Medicaid providers. Rather these providers have to work for or under contract with - for example - a community mental health center, a physician's office, a federally-qualified health center, or a rural health clinic among other entities and the entity bills (and is reimbursed by) the Medicaid Program for the services provided. This administrative regulation also establishes practitioners who may provide behavioral health services under supervision of one (1) of the aforementioned independent providers and in which case the Medicaid Program will reimburse the independent provider (billing provider) for the services.

(b) The necessity of this administrative regulation: This administrative regulation is being promulgated in conjunction with two (2) administrative regulations – 907 KAR 15:010 (Provisions and requirements regarding behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for KAR Chapter 15) - to comply with a federal mandate and to enhance recipient access to services. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use

disorder services, including behavioral health treatment" for all recipients. Currently, DMS covers substance use treatment for pregnant women and children. Additionally, this administrative regulation is necessary to enhance Medicaid recipient access to behavioral health services by expanding the providers and practitioners authorized to provide the services as independent providers or as practitioners working under the supervision of an independent provider. The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 complying with a federal mandate and by enhancing and ensuring Medicaid recipients' access to behavioral health 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 authorizing statutes by complying with a federal mandate and by enhancing and ensuring Medicaid recipients' access to behavioral health 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: Licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, and licensed psychological practitioners who wish to enroll in the Medicaid Program as independent providers will be affected by this administrative regulation. Licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide behavioral health services while working for one (1) of the aforementioned independent providers will also be affected by this administrative regulation. Medicaid recipients who qualify for behavioral health services will be affected by this 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. Individuals listed in question (3) who wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who

are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Individuals who wish to provide behavioral health services to Medicaid recipients per this administrative regulation could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An individual who enrolls with the Medicaid Program to provide behavioral health services will benefit by being reimbursed for services provided to Medicaid recipients. Behavioral health service practitioners who can work for an independent behavioral health service provider will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive these services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)

(b) On a continuing basis: The response to question (a) also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), and 42 U.S.C. 1396a(a)(30)(A).

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community

pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

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 the amendment to 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 is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced

behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)

(d) How much will it cost to administer this program for subsequent years? The response to question (a) also applies here.

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:

ADMINISTRATIVE REGULATIONS AS AMENDED BY PROMULGATING AGENCY
AND REVIEWING SUBCOMMITTEE

ARRS = Administrative Regulation Review Subcommittee
IJC = Interim Joint Committee

EDUCATION PROFESSIONAL STANDARDS BOARD
(As Amended at ARRS, January 13, 2014)

16 KAR 5:020. Standards for admission to educator preparation.

RELATES TO: KRS 161.020, 161.028, 161.030, 161.048(7)

STATUTORY AUTHORITY: KRS 161.028, 161.030

NECESSITY, FUNCTION, AND CONFORMITY: KRS 161.028(1)(b) requires the Educational Professional Standards Board to promulgate administrative regulations setting standards for approval of an educator preparation institution that offers a preparation program corresponding to a particular certificate. KRS 161.030(1) requires the board to promulgate administrative regulations establishing requirements for issuance of a certificate authorized under KRS 161.010 to 161.126. This administrative regulation establishes the standards for admission to an educator preparation program.

Section 1. Selection and Admission to Educator Preparation Programs. (1) In addition to ~~the~~**[appropriate]** National Council for Accreditation of Teacher Education standards incorporated by reference in 16 KAR 5:010, each educator preparation institution shall develop minimum standards for admission to its initial certification educator preparation programs, including university-based alternative programs established pursuant to KRS 161.048(7) in accordance with this section.

(2)~~[Beginning September 1, 2012,]~~ Admission to an undergraduate initial certification educator preparation program shall require the following:

(a) 1. A cumulative grade point average of 2.75 on a 4.0 scale; or

2. A grade point average of 3.00 on a 4.0 scale on the last thirty (30) hours of credit completed; and

(b) Successful completion of the following pre-professional skills assessments of basic knowledge administered by the Educational Testing Service with the corresponding minimum score:

1. Until August 31, 2014:

a.~~(i)~~ "Pre-Professional Skills Test: Mathematics~~["~~" (0730)" - 174; or

~~(ii)~~**[b-]** "Computerized Pre-Professional Skills Test: Mathematics~~["~~" (5730)" - 174;

~~b.(i)~~**[2-a-]** "Pre-Professional Skills Test: Reading~~["~~" (0710)" - 176; or

~~(ii)~~**[b-]** "Computerized Pre-Professional Skills Test: Reading~~["~~" (5710)" - 176; and

~~c.(i)~~**[3-a-]** "Pre-Professional Skills Test: Writing~~["~~" (0720)" - 174; or

~~(ii)~~**[b-]** "Computerized Pre-Professional Skills Test: Writing~~["~~" (5720)" - 174.

2. Beginning September 1, 2014:

a. "Praxis Core Academic Skills for Educators (CASE): Reading (5712)" - 156;

b. "Praxis Core Academic Skills for Educators (CASE): Writing (5722)" - 162; and

c. "Praxis Core Academic Skills for Educators (CASE): Mathematics (5732)" - 150.

(3)~~[Beginning September 1, 2012,]~~ Admission to a graduate level initial certification educator preparation program, including an educator preparation program established pursuant to KRS 161.048(7), shall require the following:

(a) 1. A bachelor's degree or advanced degree awarded by a regionally accredited college or university with a cumulative grade point average of 2.75 on a 4.0 scale; or

2. A grade point average of 3.00 on a 4.0 scale on the last thirty (30) hours of credit completed, including undergraduate and

graduate coursework; and

(b) 1. Successful completion of the pre-professional skills assessments in subsection (2)(b) of this section; or

2. Successful completion of the Graduate Record Exam (GRE) administered by the Education Testing Service with the following corresponding scores on the corresponding sections:

a.~~(i)~~ Verbal Reasoning taken prior to August 1, 2011 - 450; or

(ii) Verbal Reasoning taken after August 1, 2011 - 150;

b.~~(i)~~ Quantitative Reasoning taken prior to August 1, 2011 - 490; or

(ii) Quantitative Reasoning taken after August 1, 2011 - 143; and

c. Analytical Writing - 4.0.

(4)~~[Beginning September 1, 2012,]~~ Each accredited educator preparation institution shall have a formal application procedure for admission to an initial teacher preparation program, which shall include the following:

(a) Documentation that the applicant demonstrates the following:

1. Critical thinking;

2. Communication;

3. Creativity; and

4. Collaboration;

(b) Evidence that the applicant has reviewed:

1. The Professional Code of Ethics for Kentucky School Certified Personnel established in 16 KAR 1:020; and

2. The character and fitness questionnaire contained in Section III of the TC-1 incorporated by reference in 16 KAR 2:010; and

(c) A method to allow the applicant to demonstrate that the applicant understands professional dispositions expected of professional educators.

(5) Undergraduate students shall not enroll in any educator preparation program courses restricted to admitted candidates.

(6) The educator preparation program shall maintain electronic records that document that all students admitted after September 1, 2012, meet the requirements established in subsection (2) of this section.

Section 2. Annual Report. (1) Each educator preparation unit shall submit an electronic report annually to the Education Professional Standards Board that includes the following program data on each candidate admitted to educator preparation programs:

(a)~~[The candidate's]~~ Education Professional Standards Board Person Identifier;

(b)~~[The candidate's]~~ Student School Identification number;

(c)~~[The candidate's]~~ Social Security number;

(d)~~[The candidate's]~~ full name;

(e)~~[The candidate's]~~ birth date;

(f)~~[The candidate's]~~ reported ethnicity;

(g)~~[The candidate's]~~ reported gender;

(h)~~[The candidate's]~~ email address;

(i)~~[The candidate's]~~ present home mailing address;

(j)~~[The candidate's]~~ permanent home mailing address;

(k)~~[The candidate's]~~ phone number;

(l)~~[The candidate's]~~ admission date;

(m)~~[The candidate's]~~ total number of credit hours prior to admission to the institution's educator preparation program;

(n)~~[The candidate's]~~ total number of credit hours in educator preparation courses completed prior to admission to the institution's educator preparation program;

(o)~~[The candidate's]~~ grade point average at admission;

(p)~~[The candidate's]~~ current program enrollment status;

(q)~~[The candidate's]~~ program completion date;

(r)~~[The candidate's]~~ grade point average at program completion;

(s)~~[The candidate's]~~ academic major at program completion;

and

(t) ~~[The candidate's]~~ academic minor or minors at program completion, if applicable.

(2) The report shall be submitted in the following manner:

(a) The institution shall electronically submit all data identified in subsection (1) to the Education Professional Standards Board; and

(b) By September 15 of each year, each institution shall provide written confirmation by electronic mail to the Director of the Division of Educator Preparation that all required information has been entered.

(3) The preparation program shall exit any candidate who has not been enrolled in at least one (1) course required for program completion within the last eighteen (18) months.

(4) Failure to submit the annual report in accordance with this section may result in action against the program's accreditation status pursuant to 16 KAR 5:010, Section 21.

CASSANDRA WEBB, Chairperson

APPROVED BY AGENCY: October 28, 2013

FILED WITH LRC: November 5, 2013 at 1 p.m.

CONTACT PERSON: Alicia A. Sneed, Director of Legal Services, Education Professional Standards Board, 100 Airport Road, Third Floor, Frankfort, Kentucky 40601, phone (502) 564-4606, fax (502) 564-7080.

EDUCATION PROFESSIONAL STANDARDS BOARD (As Amended at ARRS, January 13, 2014)

16 KAR 6:010. Examination prerequisites for teacher certification.

RELATES TO: KRS 161.020, 161.028(1), 161.030(3), (4)

STATUTORY AUTHORITY: KRS 161.028(1)(a), 161.030(3),

(4)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 161.028(1)(a) authorizes the Education Professional Standards Board to establish standards and requirements for obtaining and maintaining a teaching certificate. KRS 161.030(3) and (4) requires the Education Professional Standards Board to select the appropriate assessments required prior to teacher certification. This administrative regulation establishes the examination prerequisites for teacher certification.

Section 1. A teacher applicant for certification shall successfully complete the applicable~~[appropriate]~~ tests identified in this administrative regulation prior to Kentucky teacher certification.

Section 2. The Education Professional Standards Board shall require the test or tests and passing scores identified in this section for each new teacher applicant and each teacher seeking an additional certificate. (1) An applicant for Interdisciplinary Early Childhood Education certification (birth to primary) shall take one (1) of the following tests and achieve the corresponding passing score or higher:

(a) "Interdisciplinary Early Childhood Education (0023)" – 166; or

(b) "Interdisciplinary Early Childhood Education (5023)" – 166.

(2) An applicant for Elementary certification (grades P-5) shall take "Elementary Education: Multi-Subjects Test (5031)" with the following passing scores on the corresponding test sections:

(a) "Reading and Language Arts (5032)" – 165;

(b) "Mathematics (5033)" – 164;

(c) "Social Studies (5034)" – 155; and

(d) "Science (5035)" – 159.

(3) An applicant for certification at the middle school level (grades 5 through 9) shall take the content test or tests based on the applicant's content area or areas with the corresponding passing scores as identified in this subsection:

(a) Middle School English and Communications:

1. Until August 31, 2014:

a. "Middle School English Language Arts (0049)" - 158; or
b. ~~[2.]~~ "Middle School English Language Arts (5049)" – 158; or
2. Beginning September 1, 2014, "Middle School English Language Arts (5047)" – 164;

(b) Middle School Mathematics:

1. Until August 31, 2014, "Middle School Mathematics (0069)" - 148; or

2. Beginning September 1, 2014, "Middle School Mathematics (5169)" – 165;

(c) Middle School Science: "Middle School Science (0439)" - 144; or

(d) Middle School Social Studies:

1. "Middle School Social Studies (0089)" – 149; or

2. "Middle School Social Studies (5089)": - 149.

(4) An applicant for certification at the secondary level (grades 8 through 12) shall take the content test or tests corresponding to the applicant's content area or areas with the passing scores identified in this subsection:

(a) Biology:

1. "Biology: Content Knowledge (0235)" - 146; or

2. "Biology: Content Knowledge (5235)" – 146;

(b) Chemistry:

1. "Chemistry: Content Knowledge (0245)" - 147; or

2. "Chemistry: Content Knowledge (5245)" – 147;

(c) Earth Science:

1. "Earth and Space Sciences: Content Knowledge (0571)" - 147; or

2. "Earth and Space Sciences: Content Knowledge (5571)" - 147;

(d) English:

1. Until August 31, 2014:

a. "English Language, Literature and Composition: Content and Analysis (0044)" – 166; or

b. ~~[2.]~~ "English Language, Literature and Composition: Content and Analysis (5044)" – 166; or

2. Beginning September 1, 2014, "English Language Arts: Content and Analysis (5039)" – 168;

(e) Mathematics:

1. Until August 31, 2014:

a. ~~(i)~~ "Mathematics: Content Knowledge (0061)" - 125; or

~~(ii)~~ ~~[b.]~~ "Mathematics: Content Knowledge (5061)" - 125; and

b. ~~[2.]~~ "Mathematics: Proofs, Models and Problems, Part 1 (0063)" - 141; or

2. Beginning September 1, 2014, "Mathematics: Content Knowledge (5161)" – 160;

(f) 1. Physics: "Physics: Content Knowledge (0265)" - 133; or

2. "Physics: Content Knowledge (5265)" - 133; or

(g) Social Studies:

1. "Social Studies: Content and Interpretation (0086)" – 153; or

2. "Social Studies: Content and Interpretation (5086)" – 153.

(5) An applicant for certification in all grades shall take the content test or tests corresponding to the applicant's area or areas of specialization identified in this subsection, and, if a passing score is established in this subsection, the applicant shall achieve the passing score or higher:

(a) Art:

1. "Art: Content and Analysis (0135)" – 161; or

2. "Art: Content and Analysis (5135)" – 161;

(b) Chinese: "Chinese (Mandarin): World Language (5665)" – 164;

(c) French: "French: World Language (5174)" - 162;

(d) German: "German: World Language (5183)" - 163;

(e) Health: "Health Education (0550)" - 630;

(f) Health and Physical Education:

1. "Health and Physical Education: Content Knowledge (0856)" - 156; and

2. "Physical Education: Movement Forms - Analysis and Design (0092)" - 151;

(g) Integrated Music:

1. Until August 31, 2013:

a. "Music: Content Knowledge (0113)" - 154; and

b. "Music: Concepts and Processes (0111)" - 145; or

2. Beginning September 1, 2013, "Music: Content and

Analysis (0114)" – 162; or
~~2. "Music: Content and Instruction (5114)" – 162; or~~
(h) Instrumental Music: ~~[1. Until August 31, 2013:~~
~~a. "Music: Content Knowledge (0113)" – 154; and~~
~~b. "Music: Concepts and Processes (0111)" – 145; or~~
~~2. Beginning September 1, 2013,] "Music: Content and~~
~~Analysis (0114)" – 162; ~~f.]~~~~
(i) Vocal Music: ~~[1. Until August 31, 2013:~~
~~a. "Music: Content Knowledge (0113)" – 154; and~~
~~b. "Music: Concepts and Processes (0111)" – 145; or~~
~~2. Beginning September 1, 2013,] "Music: Content and~~
~~Analysis (0114)" – 162; ~~f.]~~~~
(j) Latin: "Latin (0601)" – 166;
(k) Physical Education:
1. "Physical Education: Content and Design (0095)" - 169; or
2. "Physical Education: Content and Design (5095)" - 169;
(l) School Media Librarian:
1. "Library Media Specialist (0311)" - 156; or
2. "Library Media Specialist (5311)" - 156;
(m) School Psychologist: "School Psychologist (0401)" - 161;
or
(n) Spanish: "Spanish: World Language (5195)" - 168.
(6) Except as provided in subsection (7) of this section, an applicant for certification for teacher of exceptional children in Communication Disorders, Learning and Behavior Disorders, Hearing Impaired, Hearing Impaired with Sign Proficiency, Visually Impaired, or Moderate and Severe Disabilities shall take the content test or tests based on the applicant's area or areas of specialization with the corresponding passing scores as identified in this subsection:
(a) Communication Disorders:
1.a. "Special Education: Core Content Knowledge and Applications (0354)" - 151; or
b. "Special Education: Core Content Knowledge and Applications (5354)" - 151; and
2.a. "Speech-Language Pathology (0330)" - 600; or
b. "Speech-Language Pathology (5330)" – 600;
(b) Hearing Impaired:
1.a. "Special Education: Core Knowledge and Applications (0354)" - 151; or
b. "Special Education: Core Knowledge and Applications (5354)" - 151; and
2. ~~[a. Until August 31, 2013, "Education of Deaf and Hard of Hearing Students (0271)" – 167; or~~
~~b. Beginning September 1, 2013,] "Special Education: Education of Deaf and Hard of hearing Students (0272)" – 160;~~
(c) Hearing Impaired With Sign Proficiency:
1. "Special Education: Core Knowledge and Applications (0354)" - 151;
2. ~~[a. Until August 31, 2013, "Education of Deaf and Hard of Hearing Students (0271)" – 167; or~~
~~b. Beginning September 1, 2013,] "Special Education: Education of Deaf and Hard of hearing Students (0272)" – 160;~~
and
3. One (1) of the following tests with a passing score of Intermediate Level:
a. "Sign Communication Proficiency Interview (SCPI)"; or
b. "Educational Sign Skills Evaluation (ESSE)";
(d) Learning and Behavior Disorders:
1. "Special Education: Core Knowledge and Mild to Moderate Applications (0543)" - 158; or
2. "Special Education: Core Knowledge and Mild to Moderate Applications (5543)" - 158;
(e) Moderate and Severe Disabilities:
1. "Special Education: Core Knowledge and Severe to Profound Applications (0545)" - 158; or
2. "Special Education: Core Knowledge and Severe to Profound Applications (5545)" – 158; or
(f) Visually Impaired:
1.a. "Special Education: Core Knowledge and Applications (0354)" - 151; or
b. "Special Education: Core Knowledge and Applications (5354)" - 151; and

~~2. [a. Until August 31, 2013, "Teaching Students with Visual Impairments (0281)" – 161; or~~
~~b. Beginning September 1, 2013,] "Special Education: Teaching Students with Visual Impairments (0282)" - 163.~~
(7) A holder of an exceptional child certificate in Learning and Behavior Disorders or Moderate and Severe Disabilities who is seeking additional certification for any exceptional children teaching certificate listed in subsection (6) of this section shall not be required to take:
(a) "Education of Exceptional Students: Core Content Knowledge (0353);"
(b) "Special Education: Core Knowledge and Applications (0354);" or
(c) "Special Education: Core Knowledge and Applications (5354)".
(8)(a) Except as provided in paragraph (b) of this subsection, an applicant for Career and Technical Education certification to teach in grades 5 - 12 shall take the content test or tests corresponding to the applicant's area or areas of specialization identified in this paragraph, and, if a passing score is established in this paragraph, the applicant shall achieve the passing score or higher:
1. Agriculture: "Agriculture (0700)" - 520;
2. Business and Marketing Education:
a. "Business Education (0101)" - 154; or
b. "Business Education (5101)" - 154;
3. Family and Consumer Science:
a. "Family and Consumer Sciences (0121)" - 162; or
b. "Family and Consumer Sciences (5121)" - 162; or
4. Engineering and Technology Education: "Technology Education (0051)" - 159.
(b) An applicant for Industrial Education shall take the content test or tests corresponding to the applicant's area or areas of specialization with the passing scores identified in 16 KAR 6:020.
(9) An applicant for a restricted base certificate in the following area or areas shall take the content test or tests based on the applicant's area or areas of specialization with the corresponding passing scores as identified in this subsection:
(a) English as a Second Language:
~~1. "English to Speakers of Other Languages (0361)" - 157; or~~
~~2. "English to Speakers of Other Languages (5361)" – 157; ~~f.]~~~~
(b) Speech/Media Communications: "Speech Communication (0221)" - 146; or
(c) Theater: "Theatre (0641)" – 162.
(10) An applicant for an endorsement in the following content area or areas shall take the content test or tests based on the applicant's area or areas of specialization with the passing scores identified in this subsection:
(a) American Sign Language: "American Sign Language Proficiency Interview (ASLPI)" administered by the Gallaudet ~~[Galludet]~~ University – 3+;
(b) English as a Second Language: "English to Speakers of Other Languages (0361)" - 157;
(c) Learning and Behavior Disorders, grades 8 - 12:
1. "Special Education: Core Knowledge and Mild to Moderate Applications (0543)" - 158; or
2. "Special Education: Core Knowledge and Mild to Moderate Applications (5543)" - 158;
(d) Literacy Specialist:
1. "Reading Specialist (0301)" – 164; or
2. "Reading Specialist (5301)" – 164;
(e) Gifted Education, grades primary - 12: "Gifted Education (0357)" - 152; or
(f) Reading Primary through Grade 12:
1. "Teaching Reading (0204)" – 153; or
2. "Teaching Reading (5204)" - 153.

Section 3. In addition to the content area test or tests established in Section 2 of this administrative regulation, each new teacher shall take the pedagogy test and meet the passing score identified in this section that corresponds to the grade level of certification sought. If a certified teacher is seeking additional certification in any area, the applicant shall not be required to take

an additional pedagogy test.

(1) An applicant for Elementary certification (grades primary – 5) shall take one (1) of the following tests and achieve the corresponding passing score or higher:

(a) "Principles of Learning and Teaching: Grades kindergarten - 6 (0622)" – 160; or

(b) "Principles of Learning and Teaching: Grades kindergarten - 6 (5622)" – 160.

(2) An applicant for certification at the middle school level (grades 5 through 9) shall take one (1) of the following tests and achieve the corresponding passing score or higher:

(a) "Principles of Learning and Teaching: Grades 5 - 9 (0623)" – 160; or

(b) "Principles of Learning and Teaching: Grades 5 - 9 (5623)" – 160.

(3) An applicant for certification at the secondary level (grades 8 through 12) shall take one (1) of the following tests and achieve the corresponding passing score or higher:

(a) "Principles of Learning and Teaching: Grades 7 - 12 (0624)" – 160; or

(b) "Principles of Learning and Teaching: Grades 7 - 12 (5624)" – 160.

(4) An applicant for certification in all grades with a content area identified in Section 2(5) of this administrative regulation shall take one (1) of the following tests and achieve the corresponding passing score or higher:

(a) "Principles of Learning and Teaching: Grades kindergarten - 6 (0622)" – 160;

(b) "Principles of Learning and Teaching: Grades kindergarten - 6 (5622)" – 160;

(c) "Principles of Learning and Teaching: Grades 5 - 9 (0623)" – 160;

(d) "Principles of Learning and Teaching: Grades 5 - 9 (5623)" – 160;

(e) "Principles of Learning and Teaching: Grades 7 - 12 (0624)" – 160; or

(f) "Principles of Learning and Teaching: Grades 7 - 12 (5624)" – 160.

(5) An applicant applying only for certification for teacher of exceptional children shall not be required to take a separate pedagogy test established in this section. The content area test or tests established in Section 2 of this administrative regulation shall fulfill the pedagogy test requirement for a teacher of exceptional children.

(6) An applicant for Career and Technical Education certification in grades 5 through 12 shall take one (1) of the following tests and receive the identified passing score:

(a) "Principles of Learning and Teaching: Grades kindergarten - 6 (0622)" – 160;

(b) "Principles of Learning and Teaching: Grades kindergarten - 6 (5622)" – 160;

(c) "Principles of Learning and Teaching: Grades 5 - 9 (0623)" – 160;

(d) "Principles of Learning and Teaching: Grades 5 - 9 (5623)" – 160;

(e) "Principles of Learning and Teaching: Grades 7 - 12 (0624)" – 160; or

(f) "Principles of Learning and Teaching: Grades 7 - 12 (5624)" – 160.

Section 4. Assessment Recency. (1) A passing score on a test established at the time of administration shall be valid for the purpose of applying for certification for five (5) years from the test administration date.

(2) A teacher who fails to complete application for certification to the Education Professional Standards Board within the applicable recency period of the test and with the passing score established at the time of administration shall retake the applicable~~appropriate~~ test or tests and achieve the appropriate passing score or scores required for certification at the time of application.

(3) The test administration date shall be established by the Educational Testing Service or other authorized test administrator.

Section 5. (1) An applicant for initial certification shall take the assessments on a date established by:

(a) The Educational Testing Service; or

(b) The agency established by the Education Professional Standards Board as the authorized test administrator.

(2) An applicant shall authorize test results to be forwarded by the Educational Testing Service, or other authorized test administrator, to the Kentucky Education Professional Standards Board and to the appropriate teacher preparation institution where the applicant received the relevant training.

(3)(a) Public announcement of testing dates and locations shall be issued sufficiently in advance of testing dates to permit advance registration.

(b) An applicant shall seek information regarding the dates and location of the tests and make application for the appropriate examination prior to the deadline established and sufficiently in advance of anticipated employment to permit test results to be received by the Education Professional Standards Board and processed in the normal certification cycle.

Section 6. An applicant shall pay the appropriate examination fee established by the Educational Testing Service or other authorized test administrator for each relevant test required to be taken.

Section 7. An applicant who fails to achieve at least the minimum score on any of the applicable~~appropriate~~ examinations may retake the test or tests during one (1) of the scheduled test administrations.

Section 8. The Education Professional Standards Board shall collect data and conduct analyses of the scores and institutional reports provided by the Educational Testing Service or other authorized test administrator to determine the impact of these tests.

CASSANDRA WEBB, Chairperson

APPROVED BY AGENCY: October 28, 2013

FILED WITH LRC: November 5, 2013 at 1 p.m.

CONTACT PERSON: Alicia A. Sneed, Director of Legal Services, Education Professional Standards Board, 100 Airport Road, Third Floor, Frankfort, Kentucky 40601, phone (502) 564-4606, fax (502) 564-7080.

FINANCE AND ADMINISTRATION CABINET Kentucky Retirement Systems (As Amended at ARRS, December 10, 2013)

Compiler's Note: This administrative regulation was amended at the December 2013 ARRS meeting, and then was deferred as amended for review at the January 2014 ARRS meeting. It is being published in this month's Register following completion of the ARRS review.

105 KAR 1:140. Employer's administrative duties.

RELATES TO: KRS 16.583, 16.645(18), 18A.105, 61.546, 61.552(23), 61.560, 61.565, 61.569, 61.597, 61.598, 61.637(17), 61.675, 61.685, 61.702, 78.545(33), (37), 78.616, 78.625, 78.652, 26 U.S.C. 401(a)(17), (31), 403(b), 408(a), (b), 414(g)(6), 457(b), 3121(b)(10), Pub. L. 104-191, Pub. L. 111-5, Div. A, Title XIII, Div. B, Title IV, 26 C.F.R. 31.3121(b)(10)-2[31.3121(b)(1)-2], 29 C.F.R. 519.2(a), 42 C.F.R. 423.504(b)(4)(vi), 45 C.F.R. Parts 160, 162, 164[, ~~26 U.S.C. 401(a)(17), 401(a)(31), 403(b), 408(a), (b) 414(g)(6), 457(b), Pub. L. 104-191, Pub. L. 111-5, Div. A Title XIII, Div. B, Title IV]~~

STATUTORY AUTHORITY: KRS 16.645(18), 61.565, 61.645(9)(g), 61.675, 78.545(33), 78.625

NECESSITY, FUNCTION, AND CONFORMITY: KRS 61.645(9)(g) requires the Board of Trustees of the Kentucky Retirement Systems to promulgate administrative regulations necessary or proper in order to carry out the provisions of KRS

16.505 to 16.652, 61.510 to 61.705, and 78.510 to 78.852. Employers participating in the Kentucky Employees Retirement System, County Employees Retirement System and State Police Retirement System are required by KRS 16.645(18), 61.565, 61.675, 78.545(33), and 78.625 to make contributions to the retirement systems, to report creditable compensation to the retirement systems and other information that the Board of Trustees may require, and perform other duties and responsibilities as participating employers. 26 U.S.C. 401(a)(17) places a limit on the amount of creditable compensation on which contributions may be made. This administrative regulation sets out the reporting requirements for all participating agencies.

Section 1. (1) Each employer shall submit the reports required under KRS 61.675 and KRS 78.625 electronically using the secure Kentucky Retirement Systems' Employer Self Service Web site by:

(a) The Enter Report Details Module; or

(b) Uploading an electronic file that meets the requirements of the Employer Contribution Record Layout. The employer shall submit a test file to the retirement systems, which shall be reviewed for compliance with the requirements of the Employer Contribution Record Layout. If the test file is in compliance with the requirements of the Employer Contribution Record Layout, the retirement systems shall certify the electronic file and inform the employer of the month when the employer may begin using the electronic file for submitting reports. If the test file is not in compliance with the requirements of the Employer Contribution Record Layout, the retirement systems shall inform the employer of the needed corrections to the test file. The employer shall not submit a report by electronic file pursuant to this subsection until the test file is certified by the retirement systems.

(2) The retirement systems shall notify each employer of the Web address of the secure Kentucky Retirement Systems' Employer Self Service Web site and shall notify each employer if the Web address of the secure Kentucky Retirement Systems' Employer Self Service Web site changes.

(3) Each employer shall submit the contributions required by KRS 61.675 and KRS 78.625:

(a) Electronically using the secure Kentucky Retirement Systems' Employer Self Service Web site;

(b) By mailing or hand delivering a check;

(c) By the eMARS system maintained by the Finance and Administration Cabinet; or

(d) By wire transfer.

(4) The employer shall report all creditable compensation paid during a month by the tenth day of the following month.

(a) The employer shall designate the month to which the creditable compensation should be applied if it is not the month for which the employer is reporting **and** if the month the creditable compensation was earned is the month in which the employee:

1. Became employed;

2. Became eligible to participate in one of the systems administered by Kentucky Retirement Systems;

3. Was transferred to hazardous coverage from nonhazardous participation;

4. Was transferred from hazardous coverage to nonhazardous participation;

5. Terminated from employment; or

6. Became ineligible to participate in one (1) of the systems administered by Kentucky Retirement Systems.

(b) If the employee is paid creditable compensation in a lump sum or nonrecurring payment, the employer shall designate the reason for the lump sum or nonrecurring payment.

1. If the lump sum or nonrecurring payment was earned during a specific time period, the employer shall designate the time period during which the lump sum or nonrecurring payment was earned.

2. If the employer fails to designate a specific time period during which the lump sum or nonrecurring payment was earned, the payment shall be considered a lump sum bonus pursuant to KRS 16.505(8), 61.510(13), or 78.510(13).

(5) The provisions of subsection (1) of this section shall not apply to the Kentucky Personnel Cabinet or agencies that are reported by the Kentucky Personnel Cabinet.

(6) Each employer shall report employees who are regular full-time employees as defined by KRS 61.510(21) and 78.510(21) and shall remit employer and employee contributions for those employees.

(7) If an employer fails to withhold from an employee's creditable compensation the full amount of contributions due from the employee in accordance with KRS 16.583, 61.560, 61.597, or 61.702:

(a) The retirement systems shall notify the employer of the additional amount of employee contributions due from the employee;

(b) The employer shall withhold the additional contributions due from the employee in accordance with KRS 16.583, 61.560, 61.697, or 61.702 from the employee's creditable compensation and remit the additional contributions to the retirement systems;

(c) If the employee is no longer employed by the employer, the employer shall notify the retirement systems and the retirement systems shall refund the contributions submitted by the employer on behalf of the employee to the employer, which shall withhold the applicable taxes from the contributions and remit the remaining money to the employee; and

(d) If the contributions are refunded in accordance with paragraph (c) of this subsection, then that service credit shall be omitted service in accordance with KRS 61.552(23).

(8) Each employer shall report employees who are not regular full-time employees as defined by KRS 61.510(21) and 78.510(21), but shall not remit employer or employee contributions for those employees unless required to do so pursuant to KRS 61.680(6), except:

(a) Student employees of public universities participating in the Kentucky Employees Retirement System who are enrolled as full-time students in a course of study at the university and who are exempt from FICA withholding pursuant to 26 U.S.C. 3121(b)(10) and 26 C.F.R. **31.3121(b)(10)-2[31.3121(b)(1)-2]**; and

(b) Student employees of public universities participating in the Kentucky Employees Retirement System who are enrolled as full-time students in a course of study at the university and are classified as full-time students throughout the fiscal year pursuant to 29 C.F.R. 519.2(a).

(9)(a) An employer participating in Kentucky Employees Retirement System or County Employees Retirement System shall not classify an employee in more than one (1) non-participating position status during the fiscal year, except an employer participating in the County Employees Retirement System may classify an employee as probationary pursuant to KRS 78.510(21)(c) in the same fiscal year that the employer classifies the employee as seasonal, emergency, or part-time.

~~(b) [An employer participating in the County Employees Retirement System shall only classify an employee as temporary or probationary pursuant to KRS 78.510(21)(c) one (1) time. If the employee terminates employment with the employer and later returns to employment with the same employer, the employer shall not classify the employee as temporary or probationary pursuant to KRS 78.510(21).]~~

(c) [An employer participating in the Kentucky Employees Retirement System or the County Employees Retirement System shall not change an employee's position status from full-time to seasonal, temporary, or interim in the same fiscal year.]

~~(c) [(d)] An employer shall not classify an employee as a seasonal employee pursuant to KRS 61.510(21)(a) or 78.510(21)(a) unless the duties of the job can only be performed during a defined time period during a fiscal or calendar year. If the employer classifies an employee as seasonal and the employee is terminated after the defined time period during a fiscal or calendar year, there shall be a three (3) calendar month break in employment before the employer may again classify the employee as a seasonal employee, except for employers that are school boards. If an employer that is a school board classifies an employee as seasonal and the employee is terminated after the defined time period during a fiscal or calendar year, there shall be a six (6) calendar month break in employment before the employer may again classify the employee as a seasonal employee.~~

(d)/(e) If an employer violates the provisions of this subsection, the retirement systems shall determine if the employee worked or averaged the necessary hours to be in a regular full-time position as provided in KRS 61.510(21) or 78.510(21). If the employee worked or averaged the necessary hours to be in a regular full-time position as defined by KRS 78.510(21), the service credit shall be omitted service in accordance with KRS 61.552(23).

Section 2. (1) Each employer shall submit electronic mail to the retirement systems by logging on to the Kentucky Retirement Systems' secure electronic mail server.

(2)(a) If an employer submits personal information about its employees to the retirement systems in an unsecure electronic format or submits personal information regarding its employees intended to be submitted to the retirement systems to another person or entity by hand delivery, mail, fax, or in an electronic format; the employer shall notify affected employees in writing of the disclosure of personal information and provide information regarding obtaining credit reports.

(b) Personal information includes the member's first name or first initial and last name in combination with the member's:

1. Social Security number;
2. Driver's license number;

3. Personal Identification Number permitting access to the member's account; or

4. Medical Information.

(c) The retirement systems shall notify the employer of a disclosure upon discovery.

(d) The employer shall notify the retirement systems of a disclosure upon discovery.

(e) The employer shall submit a draft of the written notification to be made to affected employees to the retirement systems for approval or denial.

(f) The employer shall submit copies of the written notifications made to affected employees to the retirement systems after the notifications have been made.

(g) If the retirement systems is required by federal or state law to provide notification to affected members about the employer's disclosure of personal information or if the retirement systems determines that it should provide the notification to its affected members because of the nature or magnitude of the employer's disclosure, the employer shall reimburse the retirement systems for its costs in notifying members affected by the employer's disclosure.

(h) In transmitting any medically related personal information, the employer shall comply with[by] all statutes and regulations comprising the Health Insurance Portability and Accountability Act of 1996 "HIPAA", Pub.L. 104-191 and the Health Information Technology for Economic and Clinical Health Act "HITECH", Pub.L. 111-5.

(i) Each employer shall execute a data use agreement with retirement systems.

Section 3. (1)(a) The retirement systems shall submit an invoice to employers for any payments owed to the retirement systems, which were not paid through the normal monthly reports.

(b) The employer shall remit payment to the retirement systems by the due date provided on the invoice.

(2) The retirement systems may offset funds owed by the employer to the retirement systems with funds owed to the employer by the retirement systems.

Section 4. (1) An employer shall pay interest at the rate adopted by the board for any creditable compensation paid as a result of an order of a court of competent jurisdiction, the Personnel Board, or the Human Rights Commission or for any creditable compensation paid in anticipation or settlement of an action before a court of competent jurisdiction, the Personnel Board, or the Human Rights Commission including notices of violations of state or federal wage and hour statutes or violations of state or federal discrimination statutes.

(2) The interest shall be assessed from the time period for which the creditable compensation has been reinstated.

Section 5. If an employer refuses to provide the retirement systems access to records or information requested in accordance with KRS 61.685 or does not respond to a request for information or records by the retirement systems, the retirement systems may, if appropriate, hold all payments of:

(1) Any funds due to the employer; or

(2) Refunds or initial retirement allowances to any employee or former employee of the employer whose refund or retirement may be affected by the records or information requested by the retirement system.

Section 6. (1) Effective July 1, 1996, and before July 1, 2002, the creditable compensation on which contributions are reported shall not exceed the maximum annual compensation limit contained in 26 U.S.C. 401(a)(17), \$150,000, as adjusted for cost-of-living increases under 26 U.S.C. 401(a)(17)(B). The retirement system shall notify employers of the maximum annual compensation limit. Each employer shall report contributions on all creditable compensation up to the maximum annual limit. Once an employee's creditable compensation has reached the maximum annual limit, the employer shall continue to report the employee's creditable compensation but shall not report any further employer or employee contributions on the employee's creditable compensation. If excess contributions are erroneously reported, the retirement system shall refund the excess contributions to the employer for distribution to the employee after making payroll deductions in accordance with federal and state law.

(2) Effective only for the 1996 plan year, in determining the compensation of an employee eligible for consideration under this provision, the rules of 26 U.S.C. 414(g)(6) shall apply, except that in applying these rules, the term "family" shall include only the spouse of the member and any lineal descendants of the employee who have not attained age nineteen (19) before the close of the year.

(3) Effective with respect to plan years beginning on and after July 1, 2002, a plan member's annual compensation that exceeds \$200,000 (as adjusted for cost-of-living increases in accordance with 26 U.S.C. 401(a)(17)(B)) shall not be taken into account in determining benefits or contributions due for any plan year. Annual compensation shall include compensation during the plan year or any[such] other consecutive twelve (12) month period over which compensation is otherwise determined under the plan (the determination period). The cost-of-living adjustment in effect for a calendar year shall apply to annual compensation for the determination period that begins with or within the calendar year. If the determination period consists of fewer than twelve (12) months, the annual compensation limit shall be an amount equal to the otherwise applicable annual compensation limit multiplied by a fraction, the numerator of which is the number of months in the short determination period, and the denominator of which is twelve (12). If the compensation for any prior determination period is taken into account in determining a plan member's contributions or benefits for the current plan year, the compensation for this prior determination period shall be subject to the applicable annual compensation limit in effect for that prior period.

(4) A participating member may pay contributions for the creditable compensation over the maximum annual compensation limit for the years used to determine the member's final compensation for purposes of retirement if:

(a) The member's creditable compensation has exceeded the maximum annual compensation limit contained in 26[25] U.S.C. 401(a)(17) in years prior to the fiscal year beginning July 1, 2002;

(b) The member has filed a notification of retirement; and

(c) The excess creditable compensation is within the maximum annual compensation limit applicable in 2002-2003. Upon receipt of employee contributions, the retirement systems shall bill the employer for the employer contributions on the excess creditable compensation, and the employer shall remit the employer contributions to the retirement systems. The excess shall only be included in retirement calculations if both the employee and employer have paid their respective contributions.

Section 7. (1) An employer may request that the retirement

systems make a determination if a change in position or hiring of an employee is a bona fide promotion or career advancement prior to the employee's change of position or hiring as provided in KRS 61.598.

(2) An employer may submit a Form 6480, Employer Request for Pre-Determination of Bona Fide Promotion or Career Advancement, describing the proposed change in position or hiring of an employee or potential employee including:

- (a) The employee's or potential employee's full name;
- (b) The employee's or potential employee's Kentucky Retirement Systems Member Identification Number or Social Security Number;
- (c) The potential employee's current employer;
- (d) The employee's current job description;
- (e) The job description for the employee's proposed job;
- (f) Documentation of additional training, skills, education, or expertise gained by the employee or potential employee;
- (g) Employer's organizational chart; and
- (h) Any additional information the employer wants to be considered by the retirement systems.

(3) The employer shall provide any additional information requested by the retirement systems.

(4) The retirement systems may require the employer to make certifications regarding the information and documentation submitted.

(5) In determining if a change in position or hiring would be a bona fide promotion or career advancement, the retirement systems shall consider the **factors listed in KRS 61.598(1)(a)[following factors]:**

(a) If the employee's or potential employee's proposed job duties represent a significant increase in responsibility from the employee's previous job duties;

(b) If the employee or potential employee has gained training, skills, education, or expertise to justify a change in position; and

(c) If the employee's proposed job represents a promotion within the employee's organization from the employee's previous job].

(6) Increases or proposed increases in an employee's creditable compensation caused by overtime, compensatory time other than lump-sum payment made at the time of termination, or bonuses shall not be a bona fide promotion or career advancement.

(7) The retirement systems shall issue a final administrative decision in writing **informing the employer whether the [to the employer if an]** employee's change in position or potential employee's hiring is a bona fide promotion or career advancement. The retirement systems' determination shall be specific to the employee or potential employee and shall be based on the information and documentation provided by the employer. If the information or documentation provided by the employer is not accurate, the final administrative decision of the retirement systems shall not be binding on the retirement systems pursuant to KRS 61.685.

(8) An employer who disagrees with the retirement systems' final administrative decision may request an administrative hearing in accordance with KRS Chapter 13B. The request for administrative hearing shall be made in writing within thirty (30) days of the date of the final administrative decision of the retirement systems.

Section 8. (1) After the member retires, the retirement systems shall determine if annual increases in a member's creditable compensation greater than ten (10) percent occurred over the member's last five (5) fiscal years of employment.

(a) For each of the member's last five (5) fiscal years of employment, the retirement systems shall multiply the member's creditable compensation for the previous fiscal year by 110 percent. If the member's creditable compensation in any of his or her last five (5) fiscal years of employment is greater than the member's creditable compensation from the previous fiscal year multiplied by 110 percent, the retirement systems shall determine that an annual increase in the

member's creditable compensation greater than ten (10) percent has occurred.

(b) For purposes of performing the calculations in paragraph (a) of this subsection, the member's creditable compensation shall be annualized by dividing the member's creditable compensation for the fiscal year by the number of months of service credit, and multiplying by twelve (12).

(2) If the retirement systems determine that the member received annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment, the retirement systems shall send written notice to the member's last participating employer of the retirement systems' determination that the member has experienced annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment, and the amount of the additional actuarial cost to the retirement systems attributable to the increases.

(3) If the employer believes that the annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment was due to a bona fide promotion or career advancement, the employer shall file a Form 6481, Employer Request for Post-Determination of Bona Fide Promotion or Career Advancement, for a determination that the annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment were due to a bona fide promotion or career advancement. The Form 6481 shall be filed within **sixty (60)[thirty (30)]** days of the date of the notice. If the retirement systems had previously provided a determination that a change in position or hiring of the member would be a bona fide promotion or career advancement, the employer shall submit the determination and provide documentation that the increase in creditable compensation for that fiscal year was due to the employer implementing the proposed change in position or hiring.

(4) The employer shall provide any additional information requested by the retirement systems.

(5) The retirement systems may require the employer to make certifications regarding the information and documentation submitted.

(6) In determining if a change in position or hiring **was[would be]** a bona fide promotion or career advancement, the retirement systems shall consider the **factors listed in KRS 61.598(1)(a)[following factors]:**

(a) If the employee's or potential employee's proposed job duties represent a significant increase in responsibility from the employee's previous job duties;

(b) If the employee or potential employee has gained training, skills, education, or expertise to justify a change in position; and

(c) If the employee's proposed job represents a promotion within the employee's organization from the employee's previous job].

(7) The retirement systems shall issue a final administrative decision in writing **informing[advising]** the employer whether the annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment were due to a bona fide promotion or career advancement.

(8) If the employer fails to submit a Form 6481, Employer Request for Post-Determination of Bona Fide Promotion or Career Advancement, within **sixty (60)[thirty (30)]** days of the date of the notice, the employer shall pay the additional actuarial cost to the retirement systems attributable to annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment.

(9) If the employer disagrees with the final administrative decision by the retirement systems, the employer shall file a written request for an administrative hearing pursuant to KRS Chapter 13B within thirty (30) days of the date of the final administrative decision. **The hearing shall be limited to the issue of whether the retirement systems correctly determined that the annual increases in the member's creditable compensation greater than ten (10) percent were not due to a bona fide promotion or career advancement.**

(10) If the employer fails to file a written request for administrative hearing within thirty (30) days of the date of the final administrative decision, the employer shall pay the additional actuarial cost to the retirement systems attributable to annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment.

(11) The retirement systems shall issue an invoice to the last participating employer representing the actuarial cost to the retirement systems attributable to annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment. The employer may request that the retirement systems allow the employer to pay the cost over a period, not to exceed one (1) year, without interest and the retirement systems shall establish a payment plan for the employer.

(12) If at the time of his retirement the member was employed by more than one (1) participating employer when the member retired, the actuarial cost to the retirement systems attributable to annual increases in creditable compensation greater than ten (10) percent over the member's last five (5) fiscal years of employment shall be divided equally among the member's last participating employers.

(13) An employer who is required to pay the additional actuarial cost pursuant to KRS 61.598 shall be treated as a participating employer in the system to which the employer is required to pay the additional actuarial cost solely for purposes of making the payment required pursuant to KRS 61.598.

Section 9. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Form 6480, "Employer Request for Pre-Determination of Bona Fide Promotion or Career Advancement", July 2013; and

(b) Form 6481, "Employer Request for Post-Determination of Bona Fide Promotion or Career Advancement", ~~September~~**[July]** 2013.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, Kentucky 40601, Monday through Friday, from 8 a.m. to 4:30 p.m.

WILLIAM A. THIELEN, Executive Director

RANDY OVERSTREET, CHAIR

APPROVED BY AGENCY: October 15, 2013

FILED WITH LRC: October 15, 2013 at 9 a.m.

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GENERAL GOVERNMENT CABINET

Board of Nursing

(As Amended at ARRS, January 13, 2014)

201 KAR 20:056. Advanced practice registered nurse licensure, program requirements, recognition of a national certifying organization.

RELATES TO: KRS 218A.205(3)(g), ~~(7)[2]~~, 314.011, 314.042, 314.091, **314.103**, 314.161, 314.470

STATUTORY AUTHORITY: KRS 218A.205(3)(g), ~~(7)[2]~~, 314.042, **314.103[(7)]**, 314.131(1), ~~314.470~~

NECESSITY, FUNCTION, AND CONFORMITY: **KRS 218A.205(3)(g) requires the board to establish by administrative regulation for licensees authorized to dispense or prescribe controlled substances the process for submitting a query on each applicant to the National Practitioner Data Bank. KRS 218A.205(7) requires the board to require for any applicant for an initial licensure that authorizes the prescribing or dispensing of controlled substances to complete a state and national criminal records check.** KRS 314.131(1) authorizes the Board of Nursing to promulgate

administrative regulations necessary to enable it to carry into effect the provisions of KRS Chapter 314. KRS 314.042 requires the licensure of an advanced practice registered nurse and authorizes the board to promulgate administrative regulations establishing licensing requirements. **KRS 314.103 authorizes the board to require a criminal background investigation of an applicant or a nurse.** This administrative regulation establishes the requirements for licensure, renewal, and reinstatement, programs, and recognition of a national certifying organization.

Section 1. An applicant for licensure as an advanced practice registered nurse in Kentucky shall:

(1)(a) Complete an ~~["Application for Licensure as an Advanced Practice Registered Nurse"]~~ as required by 201 KAR 20:370, Section 1(1);

(b) Provide a copy of a current active Registered Nurse license or validation of Registered Nurse licensure if the state of licensure does not issue licensure cards;

(c) Submit the fee required by 201 KAR 20:240, Section 1(2)(k); and

(d) Comply with the requirements established in KRS 314.042 and ~~Sections 2 and 4 through 10 of~~ this administrative regulation.

(2) If the applicant is applying only for a license as an advanced practice registered nurse, the applicant shall also provide:

(a) A completed Federal Bureau of Investigation (FBI) Applicant Fingerprint Card and the fee required by the FBI that is within six (6) months of the date of the application;

(b) A report from the Kentucky Administrative Office of the Courts, Courtnet Disposition System that is within six (6) months of the date of the application;

(c) A certified copy of the court record of any misdemeanor or felony conviction as required by 201 KAR 20:370, Section 1(3); and

(d) A letter of explanation that addresses each conviction, if applicable.

(3) An applicant shall not be licensed until:

(a) A report is received from the FBI pursuant to the request submitted under subsection ~~(2)(5)~~**(a)** of this section and any conviction is addressed by the board; and

(b) A query is completed to the board's reporting agent to the National Practitioner Data Bank of the United States Department of Health and Human Services pursuant to KRS 218A.205(3)(g)**[2]** and any relevant data on the applicant is received.

Section 2. Postbasic Program of Study and Clinical Experience. (1) An applicant for licensure as an advanced practice registered nurse shall complete an organized postbasic program of study and clinical experience. This program shall conform to 201 KAR 20:062 or its substantial equivalence if from an out of state program~~the following criteria in order to be acceptable to the board. The program shall:~~

~~(a) Be an established, ongoing, and organized program offered on a routine basis to an enrollee;~~

~~(b)1. Be accredited or approved for the education of nurses by a recognized accreditation or approval body; or~~

~~2. Be sponsored by a sponsoring organization, which shall hold the accreditation or approval for the education of nurses by a recognized accreditation or approval body;~~

~~(c) Have a program design which prepares an enrollee to function in a role consistent with the advanced practice registered nursing designation;~~

~~(d) Have a program design which includes purpose, philosophy, objectives, curriculum content, and plan to evaluate achievement of objectives and measurement of learning outcomes of students;~~

~~(e) Have a designated faculty responsible for planning, development, implementation, and evaluation of curriculum and students;~~

~~(f) Include didactic components that prepare the student to perform the additional acts delineated by the board pursuant to KRS 314.011(8) and include at least pharmacology, advanced physical assessment, advanced pathophysiology, and medical~~

management of disease and differential diagnosis;

(g) ~~Include a supervised clinical experience that includes application of all the didactic components; and~~

(h) ~~Upon successful completion, award a diploma or certificate).~~

(2)(a) If the applicant for licensure as an advanced practice registered nurse completed a postbasic program of study after January 1, 2005, the applicant shall hold a master's degree, ~~for~~ doctorate, or postmaster's certificate awarding academic credit by a college or university related to the advanced practice registered nurse designation.

(b) If the applicant for licensure as an advanced practice registered nurse completed a postbasic program of study before January 1, 2005, the program shall be evaluated by the board on an individual basis to determine if the program sufficiently prepares a student for advanced practice registered nursing by complying with the requirements of 201 KAR 20:062 ~~[this section]~~.

Section 3. National Certifying Organizations. (1) A nationally established organization or agency which certifies registered nurses for advanced practice registered nursing shall be recognized by the board if it meets the following criteria:

(a) The certifying body is an established national nursing organization or a subdivision of this type of organization;

(b) Eligibility requirements for certification are delineated;

(c) Certification is offered in a role as defined by KRS 314.042(2)(a) and in a specialty areas of clinical practice consistent with the population focus ~~as~~ as ~~required by and~~ defined by KRS 314.011 and with primary or acute care competencies;

(d) Scope and standards of practice statements are promulgated;

(e) Mechanism for determining continuing competency is established; and

(f) The certifying body is accredited by the American Board of Nursing Specialties or the National Commission for Certifying Agencies.

(2) The board recognizes the following national certifying organizations:

(a) American Nurses Credentialing Center;

(b) American Midwifery Certification Board;

(c) National Board on Certification and Recertification of Nurse Anesthetists;

(d) Pediatric Nursing Certification Board;

(e) National Certification Corporation;

(f) American Academy of Nurse Practitioners; and

(g) American Association of Critical-Care Nurses Certification Corporation.

(3) ~~The following certification examinations for nurse practitioners (NP) and clinical nurse specialists (CNS) offered by the national certifying organizations identified in subsection 2 of this section shall be deemed to meet the definition of population focus of KRS 314.011(20):~~

(a) ~~Acute Care NP;~~

(b) ~~Adult NP;~~

(c) ~~Adult Psychiatric and Mental Health NP;~~

(d) ~~Family NP;~~

(e) ~~Family Psychiatric and Mental Health NP;~~

(f) ~~Gerontological NP;~~

(g) ~~Neonatal NP;~~

(h) ~~Pediatric NP;~~

(i) ~~Pediatric/Primary Care NP;~~

(j) ~~Pediatric/Acute Care NP;~~

(k) ~~Women's Health NP;~~

(l) ~~Adult Health CNS;~~

(m) ~~Adult Psychiatric and Mental Health CNS;~~

(n) ~~Child and Adolescent Psychiatric and Mental Health CNS;~~

(o) ~~Gerontological CNS;~~

(p) ~~Pediatric CNS;~~

(q) ~~Adult Acute Care CNS;~~

(r) ~~Pediatric Acute Care CNS; and~~

(s) ~~Neonatal Acute Care CNS.~~

(4) The board recognizes the Oncology Nursing Certification Corporation only for an individual ~~[those individuals]~~ who has

received certification prior to December 15, 2010 ~~[the effective date of this administrative regulation]~~ and who has ~~has~~ continually renewed his or her ~~her~~ their Kentucky advanced practice registered nurse license since that date.

Section 4. Practice Pending Licensure. (1) A registered nurse who meets all the requirements for practice as an advanced practice registered nurse, and who holds a registered nurse temporary work permit issued pursuant to 201 KAR 20:110 pending licensure by endorsement or a privilege to practice as a registered nurse, shall be authorized to practice as an advanced practice registered nurse for a period of time not to exceed the expiration date of the temporary work permit.

(2) Authorization to practice pursuant to this section shall be in the form of a letter from the board acknowledging that the applicant has met all the requirements of this section. An applicant shall not practice until the authorization letter has been issued.

(3) An individual authorized to practice pursuant to subsection (1) of this section may use the title "APRN Applicant" or "APRN App."

Section 5. License Renewal. (1) The advanced practice registered nurse license shall expire or lapse when the registered nurse license or privilege expires or lapses.

(2) To be eligible for renewal of the license as an advanced practice registered nurse, the applicant shall:

(a) Renew the registered nurse license or privilege on an active status;

(b) Submit a completed ~~["]~~Annual Licensure Renewal Application: RN and APRN~~["]~~ or a completed ~~["]~~Annual~~["]~~ APRN Licensure Renewal Application: ~~for~~ APRN with RN Compact License (not Kentucky)~~["]~~ form, as applicable, and as required by 201 KAR 20:370, Section 1(1);

(c) Submit the current renewal application fee, as established in 201 KAR 20:240, Section 1(2)(l); and

(d) Maintain current certification by a recognized national certifying organization.

(3) An advanced practice registered nurse who fails to renew the registered nurse license or privilege or is otherwise unable to legally practice as a registered nurse shall not practice as or use the title of advanced practice registered nurse until:

(a) A current active license has been issued by the board or a privilege is recognized by the board; and

(b) The advanced practice registered nurse license has been reinstated.

(4) An advanced practice registered nurse shall provide evidence of current certification by a recognized national certifying organization upon recertification and at the request of the board.

Section 6. License Reinstatement. (1) If a nurse fails to renew the advanced practice registered nurse license as prescribed by KRS 314.042 and this administrative regulation, the license shall lapse on the last day of the licensure period.

(2) To be eligible for reinstatement of the advanced practice registered nurse license, the applicant shall:

(a) Submit a completed ~~["]~~Application for Licensure as an Advanced Practice Registered Nurse~~["]~~ form as required by 201 KAR 20:370, Section 1(1);

(b) Submit the current reinstatement application fee, as established in 201 KAR 20:240, Section 1(2)(m); and

(c) Maintain current certification by a recognized national certifying organization.

(3) If the applicant is applying for reinstatement of a license as an advanced practice registered nurse, the applicant shall also provide a:

(a) Completed Federal Bureau of Investigation (FBI) Applicant Fingerprint Card and the fee required by the FBI that is within six (6) months of the date of the application;

(b) Report from the Kentucky Administrative Office of the Courts, Courtnet Disposition System that is within six (6) months of the date of the application;

(c) Certified copy of the court record of any misdemeanor or

felony conviction

as required by 201 KAR 20:370, Section 1(3); and

(d) Letter of explanation that addresses each conviction, if applicable.

Section 7. Certification or Recertification. (1)(a) An advanced practice registered nurse shall maintain current certification or recertification from one (1) of the national organizations recognized in Section 3 of this administrative regulation throughout the licensure period.

(b) The board shall conduct an audit to verify that an advanced practice registered nurse has met the requirements of subsection (1)(a) of this section.

(2)(a) A nurse who fails to attain current, active certification or recertification from one (1) of the national organizations recognized in Section 3 of this administrative regulation shall not practice or use the title of advanced practice registered nurse (APRN) until current certification or recertification is obtained.

(b) An APRN whose certification or recertification lapses prior to the expiration of the APRN license and who does not provide evidence of current certification or recertification after a request by the board shall have the APRN license voided. This action shall not be considered to be a disciplinary action. The APRN may request a hearing on this action by submitting the request in writing. If the action is upheld or not challenged, the APRN may seek reinstatement of the license in accordance with Section 6 of this administrative regulation.

(3) An advanced practice registered nurse who is decertified by the appropriate national organization shall:

(a) Notify the board of that fact; and

(b) Not practice as or use the title of advanced practice registered nurse during the period of decertification.

Section 8. (1) An application shall be valid for a period of one (1) year from the date of submission to the board.

(2) After one (1) year from the date of application, the applicant shall be required to reapply.

Section 9. The requirements of ~~[Sections 1 through 11 of]~~ this administrative regulation shall not prohibit the supervised practice of a nurse enrolled in:

(1) A postbasic educational program for preparation for advanced practice registered nursing; or

(2) An advanced practice registered nurse refresher course.

Section 10. A registered nurse who holds himself or herself out as a clinical specialist or is known as a clinical specialist shall be required to be licensed as an advanced practice registered nurse if his or her practice includes the performance of advanced practice registered nursing procedures.

Section 11. A nurse practicing as an advanced practice registered nurse who is not licensed as an advanced practice registered nurse by the board, an advanced practice registered nurse whose practice is inconsistent with the specialty to which he or she has been designated, or an advanced practice registered nurse who does not recertify and continues to practice as an advanced practice registered nurse shall be subject to the disciplinary procedures set in KRS 314.091.

SALLY BAXTER, President

APPROVED BY AGENCY: October 17, 2013.

FILED WITH LRC: November 14, 2013 at 4 p.m.

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GENERAL GOVERNMENT CABINET

Board of Nursing

(As Amended at ARRS, January 13, 2014)

201 KAR 20:061. Approval of Doctor of Nursing Practice (DNP) degree programs.

RELATES TO: KRS ~~164.295, 164.298~~ 314.111, ~~314.131~~~~[164.295, 164.298]~~[2010 Ky. Acts ch. 80]

STATUTORY AUTHORITY: KRS ~~164.298(1), 314.111(3), 314.131(1), (2)~~

NECESSITY, FUNCTION, AND CONFORMITY: KRS ~~164.298(1)~~[2010 Ky. Acts ch. 80] requires the Board of Nursing to collaborate with the Council on Postsecondary Education to establish standards for the doctor of nursing practice (DNP) degree. **KRS 314.111(3) requires the board to promulgate by administrative regulations standards set for the establishment and outcomes of nursing education programs that prepare an advanced practice registered nurse. KRS 314.131(1) and (2) authorize the board to promulgate administrative regulations to implement KRS Chapter 314 and require the board to approve nursing programs.** This administrative regulation establishes those **program** standards **for a DNP degree**.

Section 1. Notification and Initial Approval for Accredited Programs. (1)(a) A postsecondary education institution that is currently accredited by the National League for Nursing Accrediting Commission (NLNAC), now known as the Accreditation Commission for Education in Nursing (ACEN), or the Commission on Collegiate Nursing Education (CCNE) and wishes to offer the doctor of nursing practice (DNP) degree shall notify the board in writing of its intent.

(b) The notification letter shall be accompanied by the fee required by 201 KAR 20:240, Section 1(2)(p)-(q).

(2) The notification letter shall include the following:

(a) The desired date for the admission of the first class;

(b) That the Council on Postsecondary Education has been notified;

(c) That the postsecondary education institution intends to apply for additional accreditation for the DNP degree; and

(d) How the proposed track or degree complies with the provisions outlined in Section 2(2) of this administrative regulation;

(3) When the notification letter is received by the board, the board shall grant the institution initial approval.

Section 2. ~~[Application and]~~ Initial Approval for Nonaccredited Programs. (1) An institution not presently accredited by NLNAC or CCNE that desires to establish a DNP degree shall meet the following requirements:

(a) It shall be accredited as **established[outlined]** in 201 KAR 20:260, Section ~~2(1)~~;

(b) It shall submit **information[an application]** to establish a DNP degree which shall be accompanied by the fee required by 201 KAR 20:240;

(c) ~~[If At the time that]~~ the **information[application]** is submitted to the board, the **institution seeking** program **approval** shall ~~[also]~~ begin the application process with NLNAC or CCNE;

(d) **The information[An application]** shall be submitted to the board no less than twelve (12) months prior to the first intended admission of students;

(e) **The information[An application]** shall be completed under the direction of the registered nurse who shall serve as the designated **chief nursing academic officer[nursing unit administrator]** as defined in 201 KAR 20:062; and

(f) The **institution seeking approval of a** program shall not advertise or enroll students until ~~[such time that]~~ the board has granted initial approval status.

(2) The **information[application]** shall include:

(a) General information about the institution including:

1. Mission;

2. Ownership;

3. Method of financing;

4. Accreditation;

5. Enrollment;
6. Area served;
7. Institutional faculty qualifications; and
8. Resources that are sufficient to support defined outcomes and goals;

(b) An organizational chart of the institution and a written plan which describes the organization of the program of nursing and its relationship to the institution;

(c) A designation of NLNAC or CCNE as the national nursing accrediting body to be used in the development of the program;

(d) A description and rationale for the proposed DNP degree;

(e) Approval from the governing body of the institution proposing the DNP degree or other empowered approval bodies as applicable;

(f) A copy of the curriculum vitae of the registered nurse identified as the chief nursing academic officer~~[designated head of the nursing unit]~~;

(g) Results of a needs assessment, including availability of an adequate number of potential students and employment opportunities for program graduates;

(h) Evidence of support from the community of interest;

(i) A timeline for the admission of students, projected graduation of the first class, and any plans for expansion;

(j) A description of physical or virtual resources adequate to meet the needs of the faculty and students;

(k) Evidence of a sound financial base and demonstrated financial stability available for planning, implementing, and maintaining the proposed program of nursing;

(l) The philosophy of the DNP program and program outcomes for graduates;

(m) Curriculum design for each identified track to include:

1. Proposed course sequence;
2. Description of courses; and
3. Credit hours delineating those credits assigned to theory and practice;

(n) Availability of experiential practice activities sufficient to accommodate the number of students and program outcomes;

(o) A five (5) year plan for recruiting and retaining qualified nurse faculty; and

(p) A recruitment plan and five (5) year projection for student enrollment and policies and procedures for student selection and progression.

(3) A proposed DNP program that has met all the requirements of this administrative regulation including evidence that it has applied for accreditation from NLNAC or CCNE shall be granted initial approval. This designation shall be for no more than a two (2) year period of time pending review and approval by NLNAC or CCNE.

(4) If initial approval has been granted by the board, the program may proceed with implementation including the admission of students. It shall be the responsibility of the designated chief nursing academic officer~~[head of the nursing unit]~~ to notify the board of the admission and graduation of the first class.

(5) The initial approval of a DNP program shall expire eighteen (18) months from the date of approval if a class of students is not admitted.

(6) All formal communication between the DNP program and the national nursing accrediting body shall be forwarded to the board within thirty (30) days of receipt.

(7) The designated chief nursing academic officer~~[head of the nursing unit]~~ shall notify the board within five (5) business days of any change in accreditation status.

(8) The designated chief nursing academic officer~~[head of the nursing unit]~~ shall notify the board of pending visits by the national nursing accrediting body~~[and a representative of the board shall arrange a joint site visit with the national nursing accrediting body representative to evaluate on-site materials included in the program proposal. Prior to the site visit, the program of nursing shall submit requested materials that provide evidence of program compliance with the standards established by the state and the national nursing accrediting body].~~

(9) The designated chief nursing academic officer shall provide the board with a copy of the national nursing accrediting body's

report within ten (10) days of its receipt by the program~~[Following the site visit, a report shall be prepared and shared with the designated head of the nursing unit for review and correction of factual data. The representatives' site visit report shall not be construed as affirming that the proposed program plan meets requirements.~~

~~(10) The governing institution shall be notified in writing of action taken by the board on the site visit report].~~

Section 3. Standards and Final Approval. (1) In order to receive final approval, a postsecondary education institution shall provide to the board evidence that it has met the accreditation standards for doctoral education of either:

(a) The National League for Nursing Accrediting Commission; or

(b) The Commission on Collegiate Nursing Education.

(2) This evidence shall be in the form of a copy of the letter of accreditation from either organization identified in subsection (1) of this section.

(3) A postsecondary education institution that has offered a DNP degree prior to the effective date of this administrative regulation may receive final approval from the board by submitting a copy of its letter of accreditation from either organization identified in subsection (1) of this section.

(4) Failure to maintain accreditation standards may result in withdrawal of approval by the board.

Section 4. Advanced Practice Registered Nurse Tracks. A postsecondary education institution that offers tracks within the DNP degree that lead to licensure as an advanced practice registered nurse (APRN) shall meet the standards in 201 KAR 20:062 in addition to the standards set forth in this administrative regulation.

SALLY BAXTER, President

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GENERAL GOVERNMENT CABINET

Board of Nursing

(As Amended at ARRS, January 13, 2014)

201 KAR 20:062. Standards for advanced practice registered nurse (APRN) programs of nursing.

RELATES TO: KRS 314.011, 314.111, 314.131

STATUTORY AUTHORITY: KRS 314.111(3), 314.131(1), (2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.111(3) and 314.131(2) require the board to promulgate administrative regulations to set standards for the establishment and outcomes of nursing programs, to approve schools of nursing and courses preparing persons for Advanced Practice Registered Nurse (APRN) licensure, and to monitor standards for APRN competency under KRS Chapter 314. KRS 314.131(1) authorizes the board to promulgate administrative regulations to implement KRS Chapter 314. This administrative regulation establishes APRN programs of nursing standards.

Section 1. Definitions. (1) "~~APRN/Advanced Practice Registered Nurse~~" program of nursing" means the educational unit that prepares a person for practice and licensure as an advanced practice registered nurse and includes secondary or distance learning sites, if applicable.

(2) "APRN program coordinator" means that individual who is responsible for the organization of the educational component and is licensed as an APRN in the designated role.

(3) "Designated chief nursing academic officer" means that individual who has academic and administrative authority for the

overall nursing program.

(4) "National nursing accrediting body" means National League for Nursing Accreditation Commission (NLNAC), now known as the Accreditation Commission for Education in Nursing (ACEN), or the Commission for Collegiate Nursing Education (CCNE).

Section 2. Requirements for Advanced Practice Registered Nursing Programs. (1) An educational institution that offers an APRN program of advanced practice registered nursing shall ensure that the program:

(a) Is offered by or affiliated with a college or university that is accredited under 201 KAR 20:260, Section 2(1);

(b) Is a formal educational program, that is part of a doctoral, master's program, or a post-master's program in nursing with a concentration in an advanced practice registered nursing and population foci as required for licensure in KRS 314.011;

(c) Has presented evidence that it has applied for nursing program accreditation and meets accreditation standards; and

(d) Offers a curriculum that covers the scope of practice for both the category of advanced practice registered nurse as specified in KRS 314.011 and the population foci.

(2) The clinical practice component of the curriculum shall be congruent with current national professional organizations and nursing accrediting body standards applicable to the APRN role and population focus.

(3) The program shall notify the board of any changes in hours of clinical practice or accreditation status and respond to board requests for information.

(4) The program shall have financial resources sufficient to support the educational goals of the program.

(5) The program shall establish academic and professional standards for that determine admission to the program, progression in the program, and graduation from the program that shall be consistent with sound educational guidelines and recognized standards of professional conduct.

(6) The program shall notify the board regarding any plans to expand the program to additional locations or increase the student enrollment by more than fifty (50) percent from the previously admitted cohort.

(7) Voluntary closure of a program shall be in accordance with 201 KAR 20:360, Section 5.

Section 3. Currently Existing APRN Programs of Nursing. (1) APRN programs of nursing in existence as of July 15, 2010, shall seek approval from the board prior to July 15, 2011. The following materials shall be submitted along with the fee identified in 201 KAR 20:240:

(a) Details regarding each program presently enrolling students, to include:

1. The name of the institution;
2. The address of the institution;
3. Contact information for the chief nursing academic officer;
4. The degree offered; and
5. All designated clinical tracks;

(b) A copy of the most recent self-study submitted for the most recent accreditation or reaccreditation by a national nursing accrediting body; and

(c) Copies of all communication between the program and the national nursing accrediting body since the time of the site visit.

(2) The program shall meet all requirements established for curriculum, organizational structure, faculty and students as identified in this administrative regulation.

(3) Following submission of the materials, the application shall be placed on the next education committee agenda.

(4) The designated chief nursing academic officer, along with the APRN program coordinator, shall be available during the discussion of the report at the education committee to provide clarification. The committee shall make a recommendation to the board.

(5) The decision to grant full approval by the board shall be based on review of the following:

(a) Achievement and continued approval by a national nursing

accrediting body; and

(b) Adherence to all requirements of this administrative regulation.

(6) The approval period shall not exceed the approval period of the national nursing accrediting body.

(7)(a) An educational institution that is denied approval of an advanced practice registered nursing program shall meet with representatives of the board to determine actions needed;

(b) Following the meeting referenced in paragraph (a) of this subsection, the institution may request a hearing pursuant to KRS Chapter 13B by filing a written request with the board within thirty (30) days of service of the board's order denying its application for approval.

Section 4. Establishing a New APRN Program of Nursing. (1) An institution may receive consultation from the board prior to establishing an APRN program of nursing.

(2) An institution that desires to establish and conduct an APRN program of nursing shall be accredited as outlined in 201 KAR 20:260.

(3) An institution shall submit information an application to establish an APRN program of nursing along with the fee required by 201 KAR 20:240.

(4) If at the time that the information application is submitted to the board, the institution shall also begin the application process with a national nursing accrediting body.

(5) The information application shall be submitted to the board no less than twelve (12) months prior to the first intended admission of students.

(6) The information application shall be completed under the direction of the registered nurse who shall serve as the designated chief nursing academic officer or the APRN program coordinator and who meets the qualifications of an APRN program coordinator as outlined in this administrative regulation.

(7) The institution shall not advertise or enroll students until the board has granted developmental approval status.

(8) The information application shall include:

(a) General information about the governing institution including the:

1. Mission;
2. Ownership;
3. Method of financing;
4. Accreditation;
5. Enrollment;
6. Area served;
7. Institutional faculty qualifications; and
8. Resources that are sufficient to support defined outcomes and goals;

(b) An organizational chart of the institution and a written plan which describes the organization of the program of nursing and its relationship to the institution;

(c) A designation of the current or desired national nursing accrediting body to be used in the development of the program;

(d) A description and rationale for the proposed type of APRN program to include the certificate or degree to be awarded and the population foci;

(e) Approval from the governing body of the institution proposing the APRN program of nursing or other empowered approval bodies as applicable;

(f) A copy of the curriculum vitae of the registered nurse identified as the APRN program coordinator;

(g) Results of a needs assessment, including availability of an adequate number of potential students and employment opportunities for program graduates;

(h) Evidence of support from the community of interest;

(i) A timeline for the admission of students, projected graduation of the first class, and any plans for expansion;

(j) A description of physical or virtual resources adequate to meet the needs of the faculty and students;

(k) Evidence of a sound financial base and demonstrated financial stability available for planning, implementing, and maintaining the proposed program of nursing;

(l) The philosophy of the APRN program and program

outcomes for graduates;

(m) Curriculum design for each identified track to include:

1. Proposed course sequence;
2. Description of courses; and
3. Credit hours delineating those credits assigned to theory and practice;

(n) The availability of clinical experiences sufficient to accommodate the number of students to include the total number of clinical hours designated for each track or population foci;

(o) A five (5) year plan for recruiting and retaining qualified nurse faculty; and

(p) Recruitment plan and five (5) year projection for student enrollment and policies and procedures for student selection and progression.

(9) Developmental approval shall be the designation granted to an APRN program of nursing that has met all the requirements of this administrative regulation including evidence that it has applied for accreditation from a national nursing accrediting body. This designation shall be for no more than a two (2) year period of time pending review and approval by a national nursing accrediting body.

(10) When developmental approval has been granted by the board, the program may proceed with implementation including the admission of students. It shall be the responsibility of the APRN program of nursing to notify the board of the admission and graduation of the first class.

(11) Developmental approval of an APRN program shall expire eighteen (18) months from the date of approval if a class of students is not admitted.

(12) All formal communication between the APRN program of nursing and the national nursing accrediting body shall be forwarded to the board within thirty (30) days of receipt.

(13) The APRN program coordinator shall notify the board within five (5) business days of any change in accreditation status.

~~(14)(a) The APRN program coordinator shall notify the board of pending site visits by the national nursing accrediting body and a representative of the board shall arrange a joint site visit with the national nursing accrediting body representative to evaluate on-site materials included in the program proposal. (b) Prior to the site visit, the program of nursing shall submit requested materials that provide evidence of program compliance with the standards established by the state and the national nursing accrediting body).~~

~~(15) The APRN program coordinator shall provide a copy of the report of the national nursing accrediting body to the board within ten (10) days of its receipt by the program.(a) Following a site visit, a report shall be prepared and shared with the APRN program coordinator for review and correction of factual data. The representatives' site visit report shall not be construed as affirming that the proposed program plan meets requirements).~~

~~(16)The institution shall be notified in writing of action taken by the board on the site visit report.~~

~~(17) The decision to grant full approval by the board shall be based on review of the following:~~

(a) Achievement and continued full approval by a national nursing accrediting body; and

(b) Site visit reports by the board representative conducted to evaluate program compliance with administrative regulations.

~~(17)(18) The board may grant full approval for a period of time not to exceed the approval period of the national nursing accrediting body.~~

Section 4[5]. Administrative Structure of Program. (1) The designated chief nursing academic officer shall hold the following qualifications:

(a) A current, active, unencumbered registered nurse license or privilege to practice in Kentucky;

(b) A doctoral degree earned from a university accredited by the United States Department of Education;

(c) Educational preparation or experience in teaching and learning principles for adult education, including curriculum development and administration;

(d) At least two (2) years of clinical experience; and

(e) Current knowledge of APRN practice.

(2) The qualifications for the APRN program coordinator shall include:

(a) A current, active, unencumbered APRN license or privilege to practice in Kentucky;

(b) A minimum of a master's[~~masters~~] degree in nursing or health-related field in the clinical specialty from an accredited college or university which accreditation is recognized by the U.S. Department of Education;

(c) Educational preparation or experience in teaching and learning principles for adult education, including curriculum development and administration; and

(d) At least two (2) years of clinical experience.

(3) The board shall be notified in writing of a vacancy or pending vacancy in the position of the APRN program coordinator within fifteen (15) days of the program of nursing's awareness of the vacancy or pending vacancy. If the APRN program coordinator vacates the position, the designated chief nursing academic officer[~~nursing unit administrator~~] shall submit to the board in writing:

(a) The effective date of the vacancy;

(b) The name of the APRN who has been designated to assume the administrative duties for the program and a copy of his or her curriculum vitae; and

(c) Status reports from the APRN program of nursing national nursing accrediting body.

(4) If there shall be a lapse between the date of the vacancy and the date the newly-appointed APRN program coordinator assumes duties, the designated chief nursing academic officer[~~nursing unit administrator~~] or the head of the governing institution shall submit a plan of transition to ensure[~~insure~~] the continuity of the program;

(5) Progress reports shall be submitted if requested by the board;

(6) The length of the appointment of an interim APRN program coordinator shall not exceed six (6) months.

(7) Additional six (6) month periods may be granted upon request to the board based on a documented inability to fill the position.~~(8) If the individual to be appointed as the interim APRN program coordinator is not qualified pursuant to the APRN program of nursing national nursing accrediting body's standards, the designated nursing unit administrator shall petition the board for a waiver prior to the appointment.]~~

Section 5[6]. Faculty, Adjuncts, and Clinical Preceptors. (1) The qualifications for nursing faculty within the program leading to licensure as an APRN shall be as follows:

(a) A current, active, unencumbered APRN license to practice in Kentucky, unless the nurse faculty member will teach solely on-line and will not physically practice in this state in which case the nurse faculty member shall hold a current, active, unencumbered APRN license in the state in which they are located.

(b) A minimum of a master's degree in nursing or health related field in the clinical specialty;

(c) Two (2) years of APRN clinical experience; and

(d) Current knowledge, competence, and certification as an APRN in the role and population foci consistent with teaching responsibilities.

(2) Adjunct clinical faculty employed solely to supervise clinical nursing experiences of students shall meet all the faculty qualifications for the program level they are teaching as designated in subsection (1) of this section.

(3) Other qualified individuals may teach a non-clinical course or assist in teaching a clinical course in an APRN program ~~off advanced practice registered~~ nursing[~~program~~] within their area of expertise.

(4) Clinical preceptors may be used to enhance faculty-directed clinical learning experiences. Clinical preceptors shall have demonstrated competencies related to the area of assigned clinical teaching responsibilities and shall serve as a role model and educator to the student. Clinical preceptors shall be approved by faculty and meet the following requirements:

(a) Holds an unencumbered active license or multistate privilege to practice as a registered nurse and an advanced

practice registered nurse or a physician in the state in which the preceptor practices or, if employed by the federal government, holds an unencumbered active registered nurse and an advanced practice registered nurse or a physician license in the United States; and

(b) Has a minimum of one (1) year full time clinical experience in current practice as a physician or as an APRN within the role and population focus.

(5) A clinical preceptor shall function as a supervisor and teacher and evaluate the student's performance in the clinical setting. The program faculty shall retain ultimate responsibility for student learning and evaluation.

(6) The preceptor may be a practicing physician or other licensed, graduate-prepared health care provider with comparable practice focus. A majority of the preceptors shall be nurses.

(7) A clinical preceptor who is an APRN shall hold:

(a) National certification in the advanced practice category in which the student is enrolled; or

(b) Current board licensure in the advanced practice category in which the student is enrolled.

~~(8) If a preceptor cannot be found who meets the requirements, educational and experiential qualifications as determined by the nursing program, the Board of Nursing shall be notified and a waiver requested. (9) A complete list of faculty members, clinical faculty, adjuncts, and preceptor appointments shall be reported to the board in writing annually.~~

Section 6[7]. Curriculum. (1) An educational[education] program offered by an accredited college or university that offers a graduate degree or post-master's[post-masters] certificate with a concentration in the APRN role and at least one (1) population foci shall include the following components:

(a) Clinical supervision as specified by the national certifying organizations applicable to the APRN role and population focus established[set forth] in 201 KAR 20:056, Section 3(2); and

(b) Curriculum that is congruent with:

1. [J]AACN Essentials for Masters Education for Advanced Practice Nursing[] if the program grants a master's degree or post-master's certificate or [J]AACN Essentials for Doctoral Education for Advanced Nursing Practice[] if the program grants a doctoral degree; or

2. [J]NLNAC Standards and Criteria Master's and Post-Master's Certificate[] if the program grants a master's degree or post-master's certificate or [J]NLNAC Standards and Criteria Clinical Doctorate[] if the program grants a doctoral degree.

(2) APRN programs preparing for two (2) population foci or combined nurse practitioner/clinical nurse specialist shall include content and clinical experience in both functional roles and population foci.

(3) Each instructional track shall have a minimum of 500 supervised clinical hours directly related to the role and population foci, including pharmacotherapeutic management of patients.

(4) The curriculum shall contain the following three (3) separate graduate level courses in addition to APRN core courses:

(a) Advanced physiology/pathophysiology, including general principles that apply across the lifespan;

(b) Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and

(c) Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.

(5) Content specific to the role and population focus in the APRN core area shall be integrated throughout the other role and population didactic and clinical courses.

(6) The curriculum shall include:

(a) Diagnosis and management of diseases across practice settings including diseases representative of all systems and caused by major morbidities;

(b) Preparation that provides a basic understanding of the principles for decision making in the identified role; and

(c) Role preparation in one (1) of the six (6) population foci of practice identified in KRS 314.011[201 KAR 20:056].

(7) Preparation in a specialty area of practice is optional, but if included, it shall build on the APRN role/population-focus competencies. Clinical and didactic coursework shall be comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

Section 7[8]. Students. (1) A student entering into the APRN program shall have an active, unencumbered registered nurse license.

(2) A student who wishes to complete a clinical experience in this state but is enrolled in an out of state APRN program~~[pursuant to Section 11 of this administrative regulation]~~ shall have an active, unencumbered RN license in another jurisdiction, either in the U.S. or in another country. The following criteria shall be met:

(a) The APRN program of nursing is accredited by a national nursing accrediting body;

(b) The graduate program advises the student of expectations regarding student practice and required supervision;

(c) The graduate program provides direct supervision of the clinical experience and informs faculty, preceptors and clinical facilities that the student is practicing under this limited exemption; and

(d) The student limits practice to what is required for completion of the graduate program requirements.

Section 8[9]. Ongoing Approval. (1) Approved APRN programs of nursing accredited by a national nursing accrediting body may[shall] be subject to a site visit at intervals associated with their national nursing accreditation.

(2) The board requires continuous accreditation by a national nursing accrediting body.

~~(3) A joint site visit date shall be established in collaboration with the APRN program of nursing and representatives of the respective national nursing accrediting body. A specific list of information required for review shall be sent to the program at the time that the site visit date is established.~~

~~(4) Prior to the site visit, the program of nursing shall submit requested materials that provide evidence of compliance with the standards set forth by the APRN program of nursing national nursing accrediting body.~~

~~(5) Factors that may indicate the need for a focused site visit and that jeopardize program approval status shall include:~~

(a) Reported deficiencies in compliance with this administrative regulation;

(b) Noncompliance with the governing institution or program of nursing's stated philosophy, mission, program design, objectives, outcomes, or policies;

(c) Continual failure to submit records or reports to the board within the designated time frame;

(d) Failure to provide sufficient clinical learning opportunities for students to achieve stated outcomes;

(e) Failure to comply with requirements of the board or to respond to recommendations of the board within the specified time;

(f) Failure to submit communication from the accrediting agencies within the time frames identified in Section 4 of this administrative regulation;

(g) Withdrawal of accreditation for either the college or university or the national nursing accrediting body, or if accredited for less than the maximum accreditation period, the program may require additional reports regarding noncompliance;

(h) Failure to obtain approval of a change that requires approval prior to implementation;

(i) Providing false or misleading information to students or the public concerning the program of nursing;

~~(j) A change in or the inability to secure or retain a qualified APRN program coordinator or faculty as required by their national nursing accrediting body;~~

~~(k) Evidence of a high student or faculty attrition rate as compared to the state average;~~

~~(l) A change in the ownership or organizational restructuring of the governing institution; or~~

~~(k)[(m)] Those necessary for[As deemed necessary by the~~

~~board or~~] the APRN program of national nursing accrediting body to ~~evaluate~~~~[determine]~~ compliance with referenced standards.

(4)~~[(6)]~~ If the APRN program of nursing achieves reaccreditation and the board ~~finds~~~~[determines]~~ that all requirements have been met, the program shall be eligible for continuing full approval.

(5)~~[(7)]~~ The board ~~may~~~~[shall have the authority to]~~ visit a program of nursing on an announced or unannounced basis.

(6)~~[(9)]~~ Board action following a site visit:

(a) The board shall evaluate a program of nursing in terms of its compliance with this administrative regulation~~[at the same time as the national nursing accrediting body]~~.

(b) Following a site visit and prior to board consideration, a draft of the site visit report shall be made available to the APRN program coordinator for review and correction of factual data.

(c) The APRN program administration shall be available during the discussion of the report at the board committee to provide clarification.

(d) Following the board's review and decision, a letter shall be sent to the APRN program coordinator and the head of the governing institution regarding the approval status of the program of nursing and any requirements to be met along with required timelines.

(e) A program has the right at any time to present evidence to the board that any deficiencies have been corrected and may petition the board to restore full approval.

Section 9~~[10]~~. Approval Status and Withdrawal of Approval. (1) The board shall approve an APRN program of nursing if the program meets the requirements of this administrative regulation. The board may grant developmental approval for a period of two (2) years or less to an APRN program of nursing.

(2) Full approval may be granted for the same period of time that is designated by the national nursing accrediting body.

(3)(a) The APRN program coordinator of a nursing program that has its continuing approval-status rescinded by the board shall meet with representatives of the board to ~~evaluate~~~~[determine]~~ actions needed.

(b) Following this meeting, the program may request a hearing pursuant to KRS Chapter 13B by filing a written request with the board within thirty (30) days of service of the board's order rescinding continuing full-approval status.

(4) Conditional approval shall be the designation granted to a program of nursing if one (1) or more of the standards have not been met.

(a) Following the decision of the board to place a program of nursing on conditional status, the program coordinator shall be notified of the areas of deficiency and the time frame allowed for corrective action to be implemented.

(b) The APRN program coordinator shall, within thirty (30) days of the notice of the deficiencies being sent, file a plan to correct each of the deficiencies.

(c) The APRN program coordinator may, within thirty (30) days of the notice of the deficiencies, request to appear before the board to contest the board's determination of deficiencies.

(d) If the board's determination of deficiencies has not been contested or if the deficiencies being sent are upheld after a request to contest them, the board may conduct periodic evaluations of the program of nursing during the time of correction to ~~evaluate if~~~~[determine that]~~ deficiencies have been corrected.

(e) If the plan of compliance is not completed satisfactorily within the time frame set by the board and if the program of nursing has not been granted additional time for completion, the approval status of the program of nursing shall be adjusted to probational.

(5) Probational approval shall be the designation granted to a program of nursing if one (1) or more standards have continued to be unmet.

(a) Following the decision of the board to place a program of nursing on probational status, the program coordinator shall be notified of the continued areas of deficiency. A new student shall not be admitted until the time the program of nursing comes into compliance. This period of time shall not exceed one (1) academic year.

(b) The APRN program coordinator shall, within thirty (30) days of the notice of the deficiencies being sent, file a plan to correct each of the identified deficiencies.

(c) The APRN program coordinator may, within thirty (30) days, of the notice of the deficiencies, submit a request to appear before the board to contest the board's determination of deficiencies.

(d) If the board's determination of deficiencies has not been contested or if the deficiencies are upheld after a request to contest them, the board may conduct periodic evaluations of the program of nursing during the time of correction to ~~evaluate if~~~~[determine that]~~ deficiencies have been corrected.

(6) If the program of nursing has not corrected the deficiencies within one (1) academic year of being placed on probational status, a hearing pursuant to KRS Chapter 13B shall be conducted to ~~evaluate~~~~[determine]~~ whether to withdraw approval of the program of nursing.

(7) If the board decides to withdraw approval of a program of nursing, upon the effective date of the decision the program of nursing shall be removed from the official approved status listing. A program of nursing whose approval has been withdrawn shall:

(a) Allow a student who is currently enrolled in a nursing class to complete the program of nursing; or

(b) Assist a currently enrolled student to transfer to an approved program of nursing.

(8) A program of nursing whose approval has been withdrawn but continues to operate pursuant to subsection (7) of this section shall be continuously monitored by the board until the program closes.

(9) The board may return an APRN program to full approval status if the program attains and maintains adherence to this administrative regulation.

Section 10~~[11]~~. Out-of-State APRN Programs Seeking Clinical Placements in Kentucky. (1) A nursing program, located in another state or territory of the United States that wishes to provide clinical experiences in Kentucky shall seek permission from the Kentucky Council of Postsecondary education before enrolling, offering or conducting these sessions for citizens of the Commonwealth.

(2) For out-of-state nursing programs, a program shall be currently accredited in good standing with a national nursing accrediting body.

(3) An applicant who is denied approval to conduct clinical instruction in Kentucky may request a meeting with board representatives or request a hearing pursuant to KRS Chapter 13B by filing a written request with the board within thirty (30) days of service of the board's order.

(4) The board may rescind approval held by an out-of-state nursing program to conduct clinical instruction in Kentucky based on factors identified in Section 9 of this administrative regulation.

(5) A program seeking individual clinical placements of students shall submit the following at least three (3) months prior to beginning of the experience:

(a) Designated university with relevant nursing accreditation status;

(b) Student name;

(c) The clinical practice setting;

(d) The credentials of the coordinating faculty member at the out-of-state institution;

(e) Credentials of the clinical preceptor, consistent with the qualifications outlined in this administrative regulation;

(f) Evidence of the student's qualifications for participation consistent with criteria outlined in Section 8 of this administrative regulation; and

(g) Evidence of agreement of the health care facility hosting the clinical experience.

Section 12.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "AACN Essentials for Master's Education for Advanced Practice Nursing", 1996 Edition, American Association of Colleges of Nursing;

(b) "AACN Essentials for Doctoral Education for Advanced Nursing Practice", 2006 Edition, American Association of Colleges of Nursing;

(c) "NLNAC Standards and Criteria Master's and Post-Master's Certificate", 2008 Edition, National League for Nursing Accrediting Commission; and

(d) "NLNAC Standards and Criteria Clinical Doctorate", 2008 Edition, National League for Nursing Accrediting Commission.

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SALLY BAXTER, President

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GENERAL GOVERNMENT CABINET

Board of Nursing

(As Amended at ARRS, January 13, 2014)

201 KAR 20:240. Fees for applications and for services.

RELATES TO: KRS 61.874(3), 314.027(2), 314.041(8), (10) [c]([d]), 314.042(3), (6), 314.051(2), (10) [c]([d]), 314.071(1), (2), 314.073 (8), 314.075(1), 314.101(4)(7), 314.142(1)(b), 314.161, 314.171(4)

STATUTORY AUTHORITY: KRS [61.874(3)], 314.041(8), (10) [c]([d]), 314.042(3), (6), 314.051(2), (10) [c]([d]), 314.071(1), (2), 314.073 (8)(7), 314.131(1), 314.142(1)(b), 314.161

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.131 authorizes the board to promulgate administrative regulations necessary to carry out the provisions of KRS Chapter 314. KRS 314.142(1)(b) requires the board to establish an application fee for a registered nurse who applies to the board to be credentialed as a "sexual assault nurse examiner". KRS 314.161 authorizes the board to establish fees necessary to implement KRS Chapter 314. KRS 314.041(8), (10) [c]([d]), 314.042(3), (6), 314.051(2), (10) [c]([d]), 314.071(1), (2), and 314.073 (8)(7) require the board to establish fees for licensure, examination, renewal, reinstatement, and continuing education. This administrative regulation establishes those fees.

Section 1. Fees for Licensure Applications. (1) The board shall collect a fee for:

- (a) An application for licensure; and
- (b) Licensure renewal or reinstatement.
- (2) The fee for an application shall be:
 - (a) Licensure by endorsement as a registered nurse - \$150;[-]
 - (b) Licensure by endorsement as a licensed practical nurse - \$150;[-]
 - (c) Licensure by examination as a registered nurse - \$110;[-]
 - (d) Licensure by examination as a licensed practical nurse - \$110;[-]
 - (e) Renewal of license - forty (40) dollars;[-]
 - (f) Retired status - twenty-five (25) dollars;[-]
 - (g) Reinstatement of license - \$120;[-]
 - (h) Paper copy of an application - forty (40) dollars;[-]
 - (i) Full verification of licensure, credential or registration history - fifty (50) dollars;[-]
 - (j) Duplicate license or registration card or letter - thirty-five (35) dollars;[-]
 - (k) Licensure as an advanced practice registered nurse - \$150;[-]
 - (l) Renewal of licensure as an advanced practice registered nurse - forty (40) dollars;[-]
 - (m) Reinstatement of licensure as an advanced practice registered nurse - \$120;[-]
 - (n) Name change - twenty-five (25) dollars;[-]
 - (o) Application to establish a registered nurse or licensed practical nurse prelicensure program of nursing pursuant to 201

KAR 20:280 or 201 KAR 20:290 - \$2,000;[-]

(p) Information submitted[Application] to establish a doctor of nursing practice program pursuant to 201 KAR 20:061, Section 1 - \$250;[-]

(q) Information submitted[Application] to establish a doctor of nursing practice program pursuant to 201 KAR 20:061, Section 2 - \$2,000; or[-]

(r) Application to approve an advanced practice registered nurse program pursuant to 201 KAR 20:062, Section 3 - \$250.

(s) Information submitted[Application] to establish an advanced practice registered nurse program pursuant to 201 KAR 20:062, Section 3[4] - \$2,000.

(3) An application or information submitted under this section shall not be evaluated by the board unless the current fee is submitted.

Section 2. Fees for Applications for Continuing Education Approvals. The fee for an application for approval of a provider of continuing education or for a renewal or reinstatement of the approval shall be:

- (1) Initial provider approval - \$400;[-]
- (2) Reinstatement of provider approval - \$400;[-]
- (3) Renewal of approval - \$200; or[-]
- (4) Individual review of continuing education offerings - ten (10) dollars.

Section 3. Fees for Services. (1) The fee for a service shall be:

- (a) Validation of the current status of a temporary work permit, provisional license, license, or credential:
 - 1. If requested in writing in individual nurse format - fifty (50) dollars; or[-]
 - 2. If requested in writing in list format - fifty (50) dollars for the first name and twenty (20) dollars for each additional name;[-]
- (b) Copy of an examination result or transcript - twenty-five (25) dollars;[-]
- (c) Nursing certificate - thirty (30) dollars; or[-]
- (d) Release of NCLEX results to another state board of nursing - seventy-five (75) dollars.
- (2) An applicant for licensure who takes or retakes the licensure examination shall pay:
 - (a) The current examination fee required by the national council of state boards of nursing; and
 - (b) Application for licensure fee pursuant to Section 1 of this administrative regulation.
- (3) A graduate of a foreign school of nursing shall be responsible for:
 - (a) Costs incurred to submit credentials translated into English;
 - (b) Immigration documents; and
 - (c) Other documents needed to verify that the graduate has met Kentucky licensure requirements.
- (4) A programs of nursing that requires a site visit pursuant to 201 KAR 20:270, Section 2(4), shall pay the cost of the site visit to the board.

Section 4. An application shall lapse and the fee shall be forfeited if the application is not completed as follows:

- (1) For an application for licensure by endorsement, within six (6) months from the date the application form is filed with the board office;[-]
- (2) For an application for licensure by examination, within one (1) year from the date the application form is filed with the board office; or[-]
- (3) For all other applications, except for renewal of license applications, within one (1) year from the date the application form is filed with the board office.

Section 5. An applicant who meets all requirements for approval, licensure, or credential shall be issued the appropriate approval, license, or credential without additional fee.

Section 6. Fees for Sexual Assault Nurse Examiners. (1) The application fee shall be \$120.

- (2) The credential renewal fee shall be thirty-five (35) dollars.

(3) The credential reinstatement fee shall be \$120.

Section 7. A payment for an application fee that is in an incorrect amount shall be returned and the application shall not be posted until the correct fee is received.

Section 8. Bad Transaction Fee. Any transaction, including paper or electronic, submitted to the board for payment of a fee which is returned for nonpayment shall be assessed a bad transaction fee of thirty-five (35) dollars.

SALLY BAXTER, President

APPROVED BY AGENCY: October 17, 2013

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GENERAL GOVERNMENT CABINET

Board of Nursing

(As Amended at ARRS, January 13, 2014)

201 KAR 20:260. Organization and administration standards for prelicensure programs of nursing.

RELATES TO: KRS 314.041(1), 314.111(1), 314.131

STATUTORY AUTHORITY: KRS 314.111(1), 314.131(1), (2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.111(1) and 314.131(2) require the board to approve schools of nursing and courses preparing persons for licensure and to monitor standards for nurse competency under KRS Chapter 314. KRS 314.131(1) authorizes the board to promulgate administrative regulations to implement KRS Chapter 314. This administrative regulation establishes the organization and administration standards for prelicensure registered nurse or practical nurse programs.

Section 1. Definitions. (1) "NCLEX" means the National Council Licensure Examination.

(2) "Program of nursing" means the educational unit that prepares a person for licensure as a registered or licensed practical nurse and includes secondary[or distance] learning sites, if applicable.

Section 2. Organization or Administration Standards for Prelicensure Registered Nurse and Practical Nurse Programs. To be eligible for approval by the board, a program shall have:

(1) A governing institution.

(a) The governing institution that establishes and conducts the program of nursing shall hold accreditation as a postsecondary institution, college, or university by an accrediting body recognized by the U.S. Department of Education.

(b) The governing institution shall assume full legal responsibility for the overall conduct of the program of nursing. The program of nursing shall have comparable status with the other programs in the governing institution and the relationship shall be clearly delineated.

(c) The governing institution shall:

1. Designate a program administrator for the prelicensure program who is qualified pursuant to 201 KAR 20:310;

2. Assure that at least fifty (50) percent of the program administrator's time shall be dedicated to complete the duties specified in this administrative regulation at each program of nursing, up to 100 percent. [a.] A governing institution that is unable to comply with this standard may request an exemption from the board in writing.

a. [(i)] The request shall state the reasons for noncompliance and the efforts the institution has taken and will take to comply with the standard.

b. [(ii)] If the exemption is granted, it shall be for one (1) academic year. During this time, the governing institution shall not

open a new program of nursing and shall not increase enrollment at an existing program of nursing[~~b. The program administrator's time to be dedicated to completion of the duties specified in this administrative regulation shall not be less than twenty five (25) percent for each program of nursing;~~];

3. Establish administrative policies;

4. Provide evidence that the fiscal, human, physical, clinical, and technical learning resources shall be adequate to support program mission, processes, security, and outcomes;

5. Provide student support programs, services, and activities consistent with the mission of the governing institution that promote student learning and enhance the development of the student;

6. Make financial resources available to the program of nursing consistent with equivalent programs at the governing institution;

7. Employ nurse faculty pursuant to 201 KAR 20:310 in sufficient number and expertise to accomplish program outcomes and quality improvement;

8. Provide written policies for faculty related to qualifications for the position, rights and responsibilities of the position, criteria for evaluation of performance, workload, promotion, retention, and tenure;

9. Involve the nurse faculty in determining academic policies and practices for the program of nursing; and

10. Provide for the security, confidentiality, and integrity of faculty employment records.

(d) The governing institution shall provide an organizational chart that describes the organization of the program of nursing and its relationship to the governing institution;

(2) Administrative policies.

(a) There shall be written administrative policies for the program of nursing that shall be:

1. In accord with those of the governing institution; and

2. Available to the board for review.

(b) The board shall be notified in writing of a vacancy or pending vacancy in the position of the program administrator within fifteen (15) days of the program of nursing's awareness of the vacancy or pending vacancy. If the program administrator vacates the position, the head of the governing institution shall submit to the board in writing:

1. The effective date of the vacancy;

2. The name of the registered nurse who has been designated to assume the administrative duties for the program and a copy of his or her curriculum vitae;

3.a. If there is to be a lapse between the date of the vacancy and the date the newly-appointed program administrator assumes duties, the head of the governing institution shall submit a plan of transition to ensure[insure] the continuity of the program.

b. Progress reports shall be submitted if requested by the board;

4.a. The length of the appointment of an interim program administrator shall not exceed six (6) months.

b. Additional six (6) month periods may be granted upon request to the board based on a documented inability to fill the position; and

5.a. If the individual to be appointed as the interim program administrator is not qualified pursuant to 201 KAR 20:310, the head of the governing institution shall petition the board for a waiver prior to the appointment.

b. A waiver shall be granted if the individual to be appointed meets at least the minimum requirements established in 201 KAR 20:310 for nurse faculty.

(c) A written plan for the orientation of the nurse faculty to the governing institution and to the program shall be implemented.

(d) There shall be a written contract between the governing institution and each agency or institution that provides a learning experience for a student. A contract shall not be required for an observational experience.

1. The contract shall clearly identify the responsibilities and privileges of both parties.

2. The contract shall bear the signature of the administrative authorities of each organization.

3. The contract shall vest in the nurse faculty control of the student learning experiences subject to policies of the contractual

parties.

4. The contract shall be current and may include an annual automatic renewal clause.

5. The contract shall contain a termination clause by either party;

(3) A program or an interim program administrator who shall have authority and responsibility in the following areas:

(a) Development and maintenance of collaborative relationships with the administration of the institution, other divisions or departments within the institution, related facilities, and the community;

(b) Participation in the preparation and management of the program of nursing budget;

(c) Screening and recommendation of candidates for nurse faculty appointment, retention, and promotion;

(d) Within thirty (30) days of appointment to the program of nursing, submit the qualifications of all nurse faculty and clinical instructors;

(e) To provide leadership within the nurse faculty for the development, implementation, and evaluation of the program of nursing and program outcomes;

(f) To facilitate the implementation of written program policies for the following:

1. Student admission;

2. Student readmission and advance standing;

3. Student progression, which shall include:

a. The level of achievement a student shall maintain in order to remain in the program or to progress from one (1) level to another; and

b. Requirements for satisfactory completion of each course in the nursing curriculum.

4. Requirements for completion of the program;

5. Delineation of responsibility for student safety in health related incidents both on and off campus;

6. Availability of student guidance and counseling services;

7. The process for the filing of grievances and appeals by students;

8. Periodic evaluation by the nurse faculty of each nursing student's progress in each course and in the program;

9. Student conduct that incorporates[incorporate] the standards of safe nursing care; and

10. Publication and access to current academic calendars and class schedules;

(g) To facilitate the continuing academic and professional development for the nurse faculty;

(h)1. To coordinate the development and negotiation of contracts with clinical facilities, the number and variety of which shall be adequate to meet curricular outcomes; and

2. To coordinate the development of selection and evaluation criteria for clinical facilities and ensure that the criteria shall[will] be utilized by the program of nursing;

(i) The establishment of student-nurse faculty ratio in the clinical practice experience.

1. The maximum ratio of nurse faculty to students in the clinical area of patients-clients shall be defensible in light of safety, learning objectives, student level, and patient acuity.

2. The student-nurse faculty ratio shall not exceed ten (10) to one (1) in the clinical practice experience, including observational or preceptored experiences. Observational experiences shall include an assignment where a student observes nursing and where the student does not participate in direct patient or client contact but has access to a clinical instructor as needed.

3. This ratio shall not apply to on campus skill lab experiences;

(j) The submission of the Certified List of Kentucky Program of Nursing Graduates, as incorporated by reference in 201 KAR 20:070, upon student completion of all requirements for a degree, diploma, or certificate;

(k) The development and maintenance of an environment conducive to the teaching and learning process;

(l) To facilitate the development of long-range goals and objectives for the nursing program;

(m) To ensure that equipment, furnishings, and supplies shall be[are] current and replaced in a timely manner;

(n) To ensure that the nurse faculty has sufficient time to accomplish those activities related to the teaching-learning process and program outcomes;

(o) To coordinate[ef] an orientation to the roles and responsibilities of full-time, adjunct nurse faculty, and clinical instructors to the program of nursing and, as appropriate, to clinical facilities so that the mission, goals, and expected outcomes of the program shall be[are] achieved;

(p) To facilitate regular communication with the full and part time nurse faculty and clinical instructors in the planning, implementation, and evaluation of the program of nursing;

(q) To ensure that recruitment materials provide accurate and complete information to prospective students about the program including the:

1. Nature of the program, including course sequence, prerequisites, corequisites, and academic standards;

2. Length of the program;

3. Current cost of the program; and

4. Transferability of credits to other public and private institutions in Kentucky;

(r) To conduct or participate in the written evaluation of each nurse faculty member, clinical instructor, and support staff according to published criteria, regardless of contractual or tenured status;

(s) To ensure the adherence to the written criteria for the selection and evaluation of clinical facilities utilized by the program of nursing;

(t) To maintain current knowledge of requirements pertaining to the program of nursing and licensure as established in 201 KAR Chapter 20;

(u) To attend a Board of Nursing Program Administrators Orientation within one (1) year of appointment;

(v) To develop a structure to allow nurse faculty to assist in the governance of the program; and

(w) To ensure that the curriculum is implemented as submitted to the board;

(4) A system of official records and reports essential to the operation of the program of nursing maintained according to institutional policy. Provisions shall be made for the security and protection of records against loss and unauthorized distribution or use. The system shall include records of:

(a) Currently enrolled students to include admission materials, courses taken, grades received, scores for standardized tests, and clinical performance records;

(b) Minutes of faculty and committee meetings. These records shall be maintained a minimum of five (5) years, irrespective of institutional policy;

(c) Faculty records including:

1. Validation of current licensure or privilege to practice as a Registered Nurse in Kentucky;

2. Evidence of fulfilling the faculty orientation requirements established in 201 KAR 20:310, Section 3(5); and

3. Performance evaluation for faculty employed more than one (1) year;

(d) Systematic plan of evaluation;

(e) Graduates of the program of nursing; and

(f) Administrative records and reports from accrediting agencies; and

(5) Official publications including:

(a) A description of the governing institution and program of nursing;

(b) Policies on admission, progression, dismissal, graduation, and student grievance procedures;

(c) A description of student services;

(6) Clerical assistance.

[a][1-] The number of clerical assistants shall be based upon[determined-by] the number of students and faculty.

[b][2-] There shall be secretarial and clerical assistants sufficient to meet the needs of the nursing program for the administrator, faculty, and students at the designated primary location, as well as clerical support for secondary and distance learning sites, if applicable.

(7) Nurse faculty, full-time, and part-time, with the authority and

responsibility to:

- (a) Plan, implement, evaluate, and update the program;
 - (b) Assist in the design, implementation, evaluation, and updating of the curriculum using a written plan;
 - (c) Participate in the development, implementation, evaluation, and updating of policies for student admission, progression, and graduation in keeping with the policies of the governing institution;
 - (d) Participate in academic advisement and guidance of students;
 - (e) Provide theoretical instruction and clinical learning experiences;
 - (f) Evaluate student achievement of curricular outcomes related to nursing knowledge and practice;
 - (g) Develop and implement student evaluation methods and tools to measure the progression of the student's cognitive, affective, and psychomotor achievement in course and clinical outcomes based on published rubrics and sound rationale;
 - (h) Participate in academic and professional level activities that maintain the faculty member's competency and professional expertise in the area of teaching responsibility;
 - (i) Establish clinical outcomes within the framework of the course;
 - (j) Communicate clinical outcomes to the student, clinical instructor, preceptor, and staff at the clinical site;
 - (k) Assume responsibility for utilizing the criteria in the selection of clinical sites and in the evaluation of clinical experiences on a regular basis; and
 - (l) Evaluate the student's experience, achievement, and progress in relation to course or outcomes, with input from the clinical instructor and preceptor, if applicable; and
- (8) Clinical instructors with governance to:
- (a) Design, at the direction of the nurse faculty member, the student's clinical experience to achieve the stated outcomes of the nursing course in which the student is enrolled;
 - (b) Clarify with the nurse faculty member:
 - 1. The role of the preceptor;
 - 2. The course responsibilities;
 - 3. The course or clinical outcomes;
 - 4. A course evaluation tool; and
 - 5. Situations in which collaboration and consultation shall be[are] needed; and
 - (c) Participate in the evaluation of the student's performance by providing information to the nurse faculty member and the student regarding the student's achievement of established outcomes.

Section 3. Notification of Increased Enrollment. (1) A program of nursing shall submit a request for[notify the board of] an increase in enrollment by twenty (20) percent or more of the last cohort enrolled or ten (10) students, whichever is greater.

(a) The request[notification] shall be sent in writing not later than six (6) months prior to the increase.

(b) The request[notification] shall demonstrate that the program has sufficient resources to fulfill the standards established by this administrative regulation for the anticipated increase in enrollment.

These sufficient resources shall include adequate:

- 1. Number of qualified faculty;
- 2. Classroom space;
- 3. Clinical sites;
- 4. Clerical support; and
- 5. Financial support.

(2) The board shall~~conduct a site visit to~~ evaluate[determine] if the program has sufficient resources.

(3) The board shall not grant approval for the increase in enrollment unless the program has:

- (a) Full approval status; and
- (b) Program NCLEX pass rate for first time test takers for the preceding year of a minimum of eighty-five (85) percent.

SALLY BAXTER, President

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**GENERAL GOVERNMENT CABINET
Board of Nursing
(As Amended at ARRS, January 13, 2014)**

201 KAR 20:270. Programs of nursing site visits.

RELATES TO: KRS 314.111

STATUTORY AUTHORITY: KRS 314.111(2), (4), 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.111(2)[314.11] requires that site visits be made by the executive director or a board representative to evaluate compliance with board standards by agencies offering or planning to offer programs of nursing. This administrative regulation establishes procedures and requirements for site visits to programs of nursing.

Section 1. Evaluation of a Program of Nursing by a National Nursing Accrediting Body. (1) The board shall[may] accept:

(a) Accreditation by a national nursing accrediting body recognized by the United States Department of Education as evidence of compliance with the standards of 201 KAR 20:260 through 20:360; or

(b)[in lieu of] A site visit as evidence of compliance with the standards of 201 KAR 20:260 through 20:360.

(2) The program of nursing shall submit to the board a copy of the self-evaluation report submitted to the national nursing accrediting body.

(3)[a](2)] A program of nursing that seeks accreditation from a national nursing accrediting body shall submit evidence of that accreditation to the board within thirty (30) days of receiving the report from the national nursing accrediting body.

(b) The program of nursing shall submit notice of any change in its accreditation to the board within thirty (30) days of receipt of the notice from the national nursing accrediting body.

(c) Failure to submit notice of accreditation results within thirty (30) days may result in a site visit.

(4)[(3)] A program of nursing that has been granted approval based on a national nursing accrediting body's accreditation shall comply with 201 KAR 20:260 through 20:360.

(5)[(4)] The program administrator shall submit to the board any report from the national nursing accrediting body citing deficiencies or recommendations upon receipt of the report[when the report is received] by the program of nursing.

(6)[(5)] The program of nursing shall submit copies of interim reports requested by the national nursing accrediting body to the board.

(7)[(6)] If the program of nursing receives notice from the national nursing accrediting body addressing an interim report, a copy of any communication shall be sent to the board within thirty (30) days of receiving the report.

(8)[(7)] If the program of nursing is accredited for less than the maximum accreditation period, the program shall provide the board with a copy of the report addressing the items of noncompliance and additional information regarding noncompliance, if applicable, within thirty (30) days of receipt from the national nursing accrediting body.

(9)[The board may require additional reports regarding noncompliance. (8)] The board may grant full approval, but the approval shall be for a period of time not to exceed the approval period of the national nursing accrediting body.

Section 2. Programs of Nursing Site Visits. (1) Programs of nursing not accredited by a national nursing accrediting body shall be subject to a site visit at least every eight (8) years.

(2)(a) A site visit date shall be established in collaboration with the program of nursing.

(b) A specific list of information required for review shall be sent by the board to the program of nursing prior to the site visit.

(3) Prior to the site visit, the program of nursing shall submit a self-evaluation report that provides evidence of compliance with the standards established[set forth] in 201 KAR 20:260 through 20:360.

(4) Site visits to programs of nursing holding full approval status shall[may] be scheduled[reshcheduled] based upon [any-of the following]:

(a) A complaint received from faculty, students, or the general public relating to a violation of 201 KAR 20:260 through 20:360;

(b) Denial, withdrawal, or change in the program accreditation status by a national nursing accrediting body or a general academic accrediting agency;

(c) Failure to obtain approval of a change that requires approval prior to implementation, such as a change in program administrator as required by 201 KAR 20:260 or a change in curriculum as required by 201 KAR 20:320;

(d) Providing false or misleading information to students or the public concerning the program of nursing;

(e) Violation of a requirement established in 201 KAR 20:260 through 20:360;

(f) A change in or the inability to secure or retain a qualified program administrator or faculty as required by 201 KAR 20:310;

(g) Failure to provide clinical experiences necessary to meet the outcomes of the program of nursing;

(h) Evidence of a high student or faculty attrition rate as compared to the state average;

(i) Failure to maintain an annual NCLEX pass rate for first-time testers as established[set] by 201 KAR 20:360, Section 2(4) for two (2) consecutive years;

(j) A change in the ownership or organizational restructuring of the governing institution; or

(k) Necessity[As deemed necessary by the board] to determine compliance with 201 KAR 20:260 through 20:360.

(5) The scheduling of site visits during initial approval shall be based on board required reports and on evaluations submitted by the program administrator [and as required by administrative regulation].

(6) The scheduling of site visits of governing institutions planning to establish a program of nursing or a secondary[or distance learning] site shall be based upon the information submitted within the proposal for the new program as required by 201 KAR 20:280 and 20:290.

(7) The board shall have the authority to visit a program of nursing on an announced or unannounced basis.

Section 3. Board Action Following Site Visits. (1) The board shall evaluate a program of nursing in terms of its compliance with administrative regulations 201 KAR 20:260 through 20:360.

(2) Following a site visit and prior to board consideration, a draft of the site visit report shall be made available to the program administrator for review and correction of factual data.

(3) Following the board's review and decision, a letter shall be sent to the program administrator and the head of the governing institution regarding the approval status of the program of nursing as outlined in 201 KAR 20:360.

SALLY BAXTER, President

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**GENERAL GOVERNMENT CABINET
Board of Nursing
(As Amended at ARRS, January 13, 2014)**

201 KAR 20:280. Standards for initial approval of prelicensure registered nurse and practical nurse programs.

RELATES TO: KRS 314.011(5), (9), 314.111(1), (2), (3),

314.131(2)

STATUTORY AUTHORITY: KRS 314.111, 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.111 requires the board to review schools, approve qualified schools, and, if appropriate[and possibly] withdraw approval for schools of nursing. This administrative regulation establishes the standards for the development and approval of programs that[which] prepare graduates for admission to the licensure examination and to facilitate endorsement of licensure status to other states.

Section 1. Establishment of a Program of Nursing. (1) The governing institution may receive consultation from the board prior to establishing a program of nursing.

(2) The governing institution that desires to establish and conduct the program of nursing shall be accredited as established[outlined] in 201 KAR 20:260, Section 2[1].

Section 2. Letter of Intent. (1) The governing institution shall submit to the board a letter of intent to establish a prelicensure program of nursing and the fee required by 201 KAR 20:240. [The letter of intent and any additional information shall be submitted to the board no less than one (1) year prior to the anticipated opening date for the program.]

(2) The letter of intent[proposal] shall be completed under the direction or consultation of a registered nurse who meets the qualifications of a program administrator as established[outlined] in 201 KAR 20:310.

(3) The letter of intent shall include:

(a) Approval from the governing body of the institution proposing the program of nursing or other empowered approval bodies as applicable;

(b) The results of a feasibility study that includes the following information related to the need for the program of nursing:

1. Population data within the past three (3) years of both the state and the geographic area to be served;

2. Workforce supply and demand data from the past year;

3. The rationale for why the particular geographic area was chosen;

4. A survey of all hospitals, nursing homes, and other health-related facilities where graduates of the program could be hired.

a. The letter of intent shall include copies of the completed survey forms.

b. The survey forms shall include [the following questions]:

(i)[a.] How many registered nurses (RNs) and licensed practical nurses (LPNs) are employed;

(ii)[b.-What is] The attrition rate for the nurses employed each year for the past three (3) years and why does this attrition occur;

(iii)[c.] How many openings for RNs and LPNs are available at the time of the survey;

(iv)[d.] How many positions for RNs and LPNs are budgeted for the next three (3) years; and

(v) If the facility expects[e.-Is the facility expecting] to increase or decrease the number of beds in the next three (3) to five (5) years;

5. A description of the characteristics of the population in the community to be served to include current and emerging health needs based on statistical studies to include age groups and socioeconomic status;

6. A summary of how the market in this area will support the need for the program with an analysis of data and percentages;

7. A description of the applicant pool that is being targeted and how this population will be reached; and

8. The availability of qualified staff, including faculty, within a fifty (50) mile radius[Data that documents the need for the level of nurses in the areas to be served by the proposed program];

(c) Results of an investigation into the projected impact on the operation of programs of nursing within a fifty (50) mile radius, which shall include information on the wait list for these programs for the last three (3) years, and evidence that an introductory letter has been sent to the impacted programs;

(d) Documentation from cooperating healthcare agencies in the community that they will provide support for the creation of the program of nursing. [:] This documentation shall include evidence

of the agencies' intention to contribute to the achievement of the clinical objectives of the program;

(e) General information about the governing institution including the mission, ownership, method of financing, accreditation, enrollment, area served, and institutional faculty qualifications and resources;

(f) A timeline for the hiring of a full time program administrator, admission of students, and projected graduation of the first class;

(g) Evidence of a sound financial base and demonstrated financial stability available for planning, implementing, and maintaining the proposed program of nursing;

(h) A copy of the curriculum vitae of the registered nurse involved in the planning; and

(i) Description and rationale for the proposed type of program of nursing.

(4)(a) If concerns are raised about the need for the program or about the ability of the program to obtain appropriate clinical sites, a hearing shall be held before the board's education committee to act upon the letter of intent.

(b) At the conclusion of the hearing, the committee shall recommend to the board whether or not to approve the letter of intent.

(c) If the letter of intent is approved[Upon approval of the letter of intent] by the board, the governing institution shall be notified in writing that it may move to the proposal phase.[During the proposal phase.] The governing institution shall appoint a qualified program administrator and provide appropriate resources, consultants, and faculty to develop the proposed program plan.

Section 3. Proposal Phase. (1) A completed program proposal shall be submitted to the board by the governing institution for approval no less than one (1) year[eight (8) months] prior to the anticipated opening date for a program of nursing.

(2) The program shall not be announced, advertised, or students admitted to the program of nursing until developmental approval status has been granted by the board.

(3) The program proposal shall include~~[the following information]~~:

(a) Philosophy, mission, and learning outcomes of the governing institution;

(b) An organizational chart of the governing institution and written plan, which describes the organization of the program of nursing and its relationship to the institution;

(c) Proposed philosophy, mission, and learning outcomes for the proposed program;

(d) Curriculum design including proposed course sequence and credit hours delineating those credits assigned to theory and clinical;

(e) Recruitment plan and five (5) year projection for student enrollment;

(f) A five (5) year plan for recruiting and retaining qualified nurse faculty;

(g) A proposed job description for the program administrator reflecting authority and responsibility;

(h) A description of faculty offices, classrooms, clinical skills laboratory, library facilities, conference rooms, and learning resources;

(i) A description of support services for students, to include provision of health services or evidence of an emergency plan for care, academic advisement, student services, mechanism for obtaining learning resources, and financial aid;

(j) Availability and willingness of accredited agencies to provide clinical experiences across the curriculum. This information shall include the:

1. [The]Shifts and days students will work;

2. [The]Number of students each agency can accept;

3. [The]Clinical experience that will be available from each agency;

4. [The]Other nursing programs that utilize this agency; and

5. [The]Plan to avoid displacement of[how not to displace] students from existing programs;

(k) Policies and procedures for student selection and progression, including the plan to retain students so as to maintain

a low attrition rate;

(l) A plan for clerical support available to the program for planning, implementing, and maintenance of the program;

(m) A general plan for an on-going, research based planning and evaluation process that incorporates a systematic review of the program that results in continuing improvement; and

(n) A description of financial resources to support the program including a budget for the first three (3) years with projected revenues and expenditures and the amount of resources going to institutions or organizations for contractual or support services.

(4) A representative of the board shall arrange a site visit to the governing institution and the program of nursing to clarify, verify, and amplify materials included in the proposed program plan.

(a) Prior to approval being granted, a written report shall be submitted to the board by the board representative who conducts the site visit.

(b) This site visit shall not be construed as affirming that the proposed program plan meets requirements.

(5) The governing institution shall be notified in writing of action taken by the board on the proposal and the site visit report.

(a) If the board determines that all requirements have been met, the program shall be granted developmental status.

(b) If the board determines that all requirements have not been met, the program may be granted developmental status based on compliance with the terms and conditions identified in the site visit report.

(c) If the program does not comply with the terms and conditions identified in the site visit report, the program shall be denied approval.

(6) Approval to establish a program of nursing shall[may] be withdrawn if program requirements are not met and if a class is not enrolled within eighteen (18) months after the board granted developmental approval.

(a) If [the board determines that]a proposed program does not comply with 201 KAR Chapter 20[all administrative regulations of the board], developmental[er initial] approval may be withdrawn.

(b) The governing institution shall be notified in writing of the withdrawal of developmental[er initial] approval.

(7) Students shall not be admitted to the program of nursing until developmental approval has been granted by the board.

(8) Failure to submit board required reports within the designated time period may result in the withdrawal[reversing] of developmental[er initial] approval status.

(9) Employment of program administrator and faculty.

(a) The program administrator shall be the first faculty member employed, and shall have assumed full time responsibilities for the program prior to submission of the proposal to the board.

(b) The faculty as established[outlined] in 201 KAR 20:310 shall be employed in sufficient numbers to prepare for the development of the curriculum component of the program.

(10) Any deviation from the initial curriculum plan approved within the proposal shall be approved by the board before the first class begins course requirements.

(11) Written contracts for use of clinical facilities shall be executed prior to admission to the first nursing course.

(12) The program of nursing shall submit quarterly progress and evaluation reports to[which] demonstrate implementation of the approved proposal~~[as required by the board]~~.

(13) Site visits shall[may] be conducted by the board as necessary[as deemed necessary by the board].

Section 4. Approval Status. (1) The status of the program shall move automatically from developmental to initial approval upon admission of the first class. It shall be the responsibility of the program of nursing to notify the board of the admission of the first class.

(2)~~[Full approval shall be the designation granted to a program of nursing that has implemented the approved proposal and that continues to meet standards.~~

~~(3) A program with initial approval shall be eligible for full approval upon graduation of the first class providing there is evidence that standards have been met.~~

(4) The program shall notify the board in writing thirty (30) days prior to the graduation of the first class.

(3)(5) Within ninety (90) days of graduation of the first class, the faculty shall conduct a self-study that evaluates the establishment of the program of nursing to the approved proposal and submit a written report to the board prior to consideration for full approval.

(4)(6) The decision to grant full approval shall be based on review of the following:

(a) The Program evaluation by the faculty and the program administrator;

(b) Site visit report by the board representative conducted to evaluate program compliance with administrative regulations; and

(c) Other facts that pertain to the program and reports deemed necessary to document that standards have been met.

(5) After receipt of the self-study, the board shall determine the approval status of the program as established[set forth] in 201 KAR 20:360, Section 1(3).

SALLY BAXTER, President

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GENERAL GOVERNMENT CABINET

Board of Nursing

(As Amended at ARRS, January 13, 2014)

201 KAR 20:290. Standards for prelicensure registered nurse and practical nurse secondary[or distance learning] sites.

RELATES TO: KRS 314.011(5), (9), 314.111(1), (2), (3)

STATUTORY AUTHORITY: KRS 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.131(1) authorizes the Board of Nursing to promulgate administrative regulations to implement KRS Chapter 314. KRS 314.111 requires nursing programs to be approved by the board. This administrative regulation establishes standards for the development and approval of secondary sites[or distance learning programs].

Section 1. Definition. "Secondary[or distance learning] site" means a nonmain location where educational activities are conducted and that meets the requirements of Section 2(2) of this administrative regulation.

Section 2. Establishment of a Nursing Secondary[or Distance Learning] Site. (1) The addition of a secondary[or distance learning] site shall not be considered unless the program of nursing meets the requirements established in paragraphs (a) through (c) of this subsection.[following:]

(a) The governing institution that establishes and conducts the program of nursing shall be accredited as outlined in 201 KAR 20:260, Section 2[1].

(b) The program of nursing shall hold full approval for a minimum of three (3) years.[-; and]

(c) First time test takers from the program of nursing shall have achieved an overall pass rate as established[set] by 201 KAR 20:360, Section 2(4), on the NCLEX examination for a minimum of three (3) consecutive years.

(2) The addition of a secondary[or distance learning] site shall not be considered unless one (1) of the following is met:

(a) A student may obtain at the site fifty (50) percent or more of the necessary credits towards a degree or diploma program;

(b) A student may obtain at the site fifty (50) percent or more of the necessary credits towards a degree or diploma program via an electronic method; or

(c) Students at the site utilize services provided at the main

campus that oversees the site because of the site's geographic proximity[closeness] to the main campus.

Section 3. Letter of Intent. (1) The governing institution shall submit to the board a letter of intent to establish a secondary[or distance learning] site along with the fee required by 201 KAR 20:240. The letter of intent and additional preliminary information shall be supplied to the board at least six (6) months prior to the desired admission of the first class.

(2) The letter of intent shall be completed under the direction or consultation of a registered nurse who meets the qualifications of a program administrator as established[outlined] in 201 KAR 20:310.

(3) The letter of intent shall include:(a) The name of the governing institution accredited by an accrediting body recognized by the United States Department of Education;

(b) The consent of the approving board or body of the governing institution;

(c) General information about the governing institution including the mission, ownership, method of financing, accreditation, enrollment, area served, and institutional faculty qualifications and resources;

(d) Documentation of the need for the level of nurses in the area to be served by the secondary[or distance learning] site;

(e) Documentation from cooperating healthcare agencies in the community that will provide support for the creation of the secondary[or distance learning] site. This documentation shall include evidence of the agencies' intention to contribute to the achievement of the clinical objectives of the site;

(f) Investigation of the projected impact on the operations of all programs of nursing within a fifty (50) mile radius of the site. Evidence that an introductory letter was sent to the impacted programs shall be included; and

(g) A timeline for the admission of students and graduation of the first class.

(4) Upon approval of the letter of intent by the board, the governing institution shall be notified in writing.

Section 4. Proposal Phase. (1) The secondary[or distance learning] site shall not be announced, advertised, or students admitted until the proposal has been approved and developmental status has been granted by the board.

(2) Developmental status shall be granted to the proposal to establish a secondary[or distance learning] site upon presentation to the board of evidence of the following:

(a) Participation by the program administrator in planning the secondary[or distance learning] site;

(b) The name and qualifications of the program administrator;

(c) The name and qualifications of the assistant program administrator as established[defined] in 201 KAR 20:310;

(d) Philosophy, purpose, and objectives of the governing institution, program of nursing, and the proposed secondary[or distance learning] site;

(e) Administrative and academic policies of the governing institution, program of nursing, and the proposed secondary[or distance learning] site;

(f) Identification of any differences between the policies to be utilized at the secondary[or distance learning] site as compared to the primary location;

(g) Organizational plan and administrative policies for implementation of the secondary[or distance learning] site;

(h) Adequacy and availability of student services consistent with those at the main campus;

(i) Plan for employment of qualified faculty who shall be employed sufficiently in advance of the opening date to provide for program planning and development and for orientation to the facilities;

(j) An identified curriculum and conceptual or organizing framework to be used and any planned revisions;

(k) The availability and willingness of accredited agencies to provide clinical experiences across the curriculum;

(l) Evidence of availability of adequate finances to support the secondary[or distance learning] site, which shall include:

1. Sufficient financial resources as identified in an approved budget for the secondary~~[or distance learning]~~ site;
2. The source of the funding identified;
3. The stability of the source of funding to maintain the operation of the secondary~~[or distance learning]~~ site; and
4. Any stipulations for use of any special finances;
- (m) The availability of adequate classrooms, laboratories, conference rooms, and library resources appropriate for the needs of the secondary~~[or distance learning]~~ site, which shall include:
 1. Sufficient space and equipment allocated for use of faculty and students as established~~[outlined]~~ in 201 KAR 20:350; and
 2. Library and learning resources that support achievement of meeting curricular objectives and future plans for maintaining these resources;
- (n) A plan for evaluation of the secondary~~[or distance learning]~~ site consistent with 201 KAR 20:360; and
- (o) The effects of the secondary~~[or distance learning]~~ site on the governing institution and the program of nursing.

Section 5. Proposal Review Process. (1) A completed program proposal shall be submitted to the board by the governing institution no less than six (6) months prior to the anticipated opening date for the secondary~~[or distance learning]~~ site.

(2) A representative of the board shall conduct a site visit to the secondary~~[or distance learning]~~ site and submit a written report to the board.

(3) The governing institution shall be notified in writing of action taken by the board on the proposal and the site visit.

(4)(a) If ~~[the board determines that]~~ the requirements of 201 KAR 20:260 through 20:360 have been met, the program shall be granted developmental status.

(b) If ~~[the board determines that]~~ all of the regulatory requirements have not been met, the program may be granted developmental status based on compliance with the terms and conditions identified.

(c) If the program does not comply with the terms and conditions identified, approval shall be denied.

(5) Students shall not be admitted to the secondary~~[or distance learning]~~ site until developmental status has been granted by the board.

(6)(a) Approval to establish a secondary~~[or distance learning]~~ site shall~~[may]~~ be withdrawn if the requirements of 201 KAR 20:260 through 20:360 are not met or if a student class is not enrolled within eighteen (18) months.

(b) If ~~[the board determines that]~~ a proposed program does not comply with all of the regulatory requirements, developmental ~~[or initial]~~ approval may be withdrawn.

(c) The governing institution shall be notified in writing of the withdrawal of developmental or initial approval.

Section 6. Approved Secondary~~[or Distance Learning]~~ Sites. (1) Reports shall be submitted to the board in accordance with 201 KAR 20:360.

(2) The status of the proposal shall automatically move from developmental to initial approval upon admission of the first class. The program of nursing shall notify the board of the admission of the first class.

(3) Full approval shall be the designation granted to a secondary~~[or distance learning]~~ site that has implemented the proposal and that continues to meet standards of 201 KAR 20:260 through 20:360.

(4) A secondary~~[or distance learning]~~ site shall be eligible for full approval upon graduation of the first class if there is evidence that the regulatory standards have been met in accordance with subsection (7) of this section.

(5) The program of nursing shall notify the board in writing at least thirty (30) days prior to the graduation of the first class.

(6) Within ninety (90) days of graduation of the first class, the faculty shall conduct a self study that evaluates the establishment of the secondary~~[or distance learning]~~ site according to the proposal and shall submit a written report to the board prior to consideration for full approval.

(7) The decision to grant full approval shall be based upon a

review of ~~[the following]~~:

(a) The program evaluation by the faculty and the program administrator;

(b) The site visit report by the board representative conducted to evaluate compliance with 201 KAR 20:260 through 20:360; and

(c) Other facts that pertain to the secondary~~[or distance learning]~~ site and reports deemed~~[necessary]~~ to document that standards have been met.

(8) The retention of full approval of a secondary~~[or distance learning]~~ site shall be contingent on meeting standards as established~~[set forth]~~ in 201 KAR 20:260 through 20:360.

SALLY BAXTER, President

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GENERAL GOVERNMENT CABINET

Board of Nursing

(As Amended at ARRS, January 13, 2014)

201 KAR 20:310. Faculty for prelicensure registered nurse and practical nurse programs.

RELATES TO: KRS 314.111, 314.470

STATUTORY AUTHORITY: KRS 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.131(1) authorizes the Board of Nursing to promulgate administrative regulations necessary to enable it to carry into effect the provisions of KRS Chapter 314. This administrative regulation establishes standards for faculty of programs of nursing that/which prepare graduates for licensure as registered nurses or practical nurses.

Section 1. Definition. "Nursing experience" means employment in a position that requires the individual to hold an active nursing license, such as nursing clinical practice, nursing administration, nursing education, or nursing research.

Section 2. Faculty for Prelicensure Registered Nurse and Practical Nurse Programs. (1)(a) The faculty shall include a program administrator and shall include at least two (2) nurse faculty (one (1) of whom may also serve as program administrator).

1. The faculty may include clinical instructors in the major areas of nursing practice.

2. The faculty shall be adequate in number to implement the curriculum as determined by program outcomes, course objectives, the level of the students, the number of students and classes admitted annually, and any additional secondary site, or continuing education programs conducted, and the educational technology utilized.

(b) The program administrator and all nurse faculty and clinical instructors shall be appointed by and be responsible to the governing institution of the program of nursing.

(c) A program of nursing shall designate an assistant program administrator for a secondary site. At least twenty (20) percent of the assistant program administrator's time shall be dedicated to complete administrative duties.

(d) A program shall develop and implement a plan of organization and administration that clearly establishes~~[delineates]~~ the lines of authority, accountability, and responsibility among all program locations and assistant program administrators.

(2) The program administrator for a Registered Nurse program shall have the following qualifications:

(a) A minimum of a master's~~[masters]~~ or higher degree in nursing from an accredited college or university;

(b) A minimum of five (5) years of nursing experience within the immediate past ten (10) years and demonstrated leadership

experience;

(c) A minimum of two (2) years of full time teaching experience at or above the academic level of the program of nursing; and

(d) An unencumbered current license, privilege, or temporary work permit to practice as a registered nurse in the Commonwealth of Kentucky.

(3) The program administrator for a Practical Nurse program shall have ~~the following qualifications~~:

(a) A baccalaureate or higher degree with a major in nursing from an accredited college or university;

(b) A minimum of five (5) years of nursing experience within the past ten (10) years with demonstrated leadership experience;

(c) Current unencumbered license, privilege, or temporary work permit to practice as a registered nurse in the Commonwealth of Kentucky; ~~and~~

(d) A minimum of two (2) years full time teaching experience at or above the academic level of the program of nursing; and

(e) A current knowledge of nursing practice at the practical or vocational level.

(4)(a) Nurse faculty or an assistant program administrator in a baccalaureate degree prelicensure registered nurse program shall hold a degree from an accredited college or university, which shall include:

1. A ~~master's~~~~[masters]~~ degree within the discipline of nursing or have completed that portion that would be equivalent to a ~~master's~~~~[masters]~~ in nursing degree; or

2. A baccalaureate degree with a major in nursing and a ~~master's~~~~[masters]~~ degree in a related field, which includes a minimum of eighteen (18) graduate hours in nursing. The eighteen (18) graduate hours in nursing may also be earned independently of the related ~~master's~~~~[masters]~~ degree.

(b) Nurse faculty or an assistant administrator in an associate degree prelicensure registered nurse program shall hold a degree from an accredited college or university, which shall include:

1. A ~~master's~~~~[masters]~~ degree within the discipline of nursing or have completed that portion of a nursing program that would be equivalent to a ~~master's~~~~[masters]~~ in nursing degree;

2. A baccalaureate degree with a major in nursing and a ~~master's~~~~[masters]~~ degree in a related field, which includes a minimum of eighteen (18) graduate hours in nursing. The eighteen (18) graduate hours in nursing may also be earned independently of the related ~~master's~~~~[masters]~~ degree; or

3. A baccalaureate degree with a major in nursing or have completed that portion of a state approved program of nursing that would be equivalent to a baccalaureate degree, and the nurse faculty member shall complete within five (5) years of hire a ~~master's~~~~[masters]~~ degree commensurate with either subparagraph 1 or 2 of this paragraph.

(c) Nurse faculty or an assistant administrator in a practical nurse program shall have a minimum of a baccalaureate degree with a major in nursing from an accredited college or university.

(d) The nurse faculty shall hold a temporary work permit or a current license or privilege to practice as a registered nurse in the Commonwealth of Kentucky.

(e) The nurse faculty shall document a minimum of two (2) years full time or equivalent experience as a registered nurse within the immediate past five (5) years and shall maintain expertise appropriate to teaching responsibilities.

(f) The nurse faculty shall document preparation in educational activities in the area of teaching and learning principles for adult education, including curriculum development and implementation. The preparation shall be acquired through planned faculty in-service learning activities, continuing education offerings, or academic courses.

(g) Nurse faculty shall maintain expertise in the clinical or functional area of responsibility.

(h) Nurse faculty hired without prior teaching experience shall have a mentor assigned and an educational development plan implemented.

(i) ~~1.~~ Nonnurse faculty members who teach nursing courses required within the curriculum shall have appropriate academic and experiential qualifications for the program areas in which they participate.

~~2.~~ Nonnurse faculty shall be required to collaborate with a nurse faculty member in order to meet the nursing course outcomes.

(j) Nurse faculty who teach on-line and will not physically practice within the state shall hold an unencumbered active nursing license or multistate privilege to practice as a registered nurse in the state where they are located.

Section 3. Clinical Preceptors. (1) A clinical preceptor may be used to enhance clinical learning experiences. ~~If a clinical preceptor is used, it shall be done,~~ after a student has received clinical and didactic instruction from the program faculty in all basic areas for the course or specific learning experience.

(2) A clinical preceptor shall hold a current unencumbered license, privilege, or temporary work permit to practice as a registered nurse in Kentucky ~~or in the state of the student's clinical site~~. In a practical nursing program, a clinical preceptor may hold a current unencumbered license, privilege or temporary work permit to practice as a licensed practical nurse in Kentucky ~~or in the state of the student's clinical site~~.

(3) A clinical preceptor shall have evidence of clinical competencies related to the area of assigned clinical teaching responsibilities and serve as a role model to the student.

(4) A clinical preceptor shall not be used to replace clinical instructors. Clinical instructors or nurse faculty retain responsibility for student learning and confer with the clinical preceptor and student for monitoring and evaluating learning experiences.

(5) There shall be documentation of orientation to the course, program outcomes, student learning objectives, evaluation methods to be utilized, and documented role expectations of faculty, preceptor, and student.

Section 4. Evaluation of Registered Nurse Program and Practical Nurse Program Faculty. (1) Evaluation of faculty records. The program administrator shall submit to the board the qualifications of nurse faculty and clinical instructors upon appointment.

(a) Official academic transcripts or copies verified by the nurse administrator or designee shall be available to the board upon request.

(b) A complete and official record of qualifications and workload for each faculty member shall be on file and available to the board upon request.

(c) Faculty appointments shall be reported to the board in writing.

(d) The program administrator shall report a change in faculty composition within thirty (30) days of appointment or vacancy.

(2) Reevaluation of faculty records. The board shall review annually the qualifications of the faculty employed in the program of nursing.

Section 5. Faculty Supervision of Student Clinical Practice. (1) The ratio of students to a nurse faculty member or clinical instructor is set by 201 KAR 20:260, Section 2(3)(i).

(2) The clinical instructor shall function under the guidance of the nurse faculty responsible for a given course.

(3) For Registered Nurse educational programs, the educational preparation of the clinical instructor shall at least equal the level of the appointing program.

(4) The clinical instructor shall hold a current unencumbered license, privilege, or temporary work permit to practice as a registered nurse in Kentucky or in the state of the student's clinical site.

(5) A clinical instructor shall have a minimum of two (2) years full time or equivalent experience within the functional area as a registered nurse within the immediate past five (5) years and evidence of clinical competence.

Section 6. Faculty Waiver. (1) All nurse faculty members ~~shall~~~~are expected to~~ meet qualifications ~~established~~~~as set forth~~ in this administrative regulation. The program administrator may request a time-limited temporary waiver if a program of nursing meets the following criteria:

- (a) Full approval status;
 - (b) Program NCLEX pass rate for first time test takers for the preceding year of a minimum of eighty-five (85) percent;
 - (c) The program has not requested a waiver for the previous two (2) years; and
 - (d) Faculty turnover for the past academic year does not exceed thirty (30) percent.
- (2) A maximum of two (2) faculty waivers shall be permitted at any one (1) time per program.
- (3) The waiver shall be requested by the program administrator. The faculty appointment shall not be implemented by the program until the board has approved it.
- (4) A waiver shall be limited to one (1) time for any individual.

SALLY BAXTER, President

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GENERAL GOVERNMENT CABINET
Board of Nursing
(As Amended at ARRS, January 13, 2014)

201 KAR 20:320. Standards for curriculum of prelicensure nursing programs.

RELATES TO: KRS 314.011(5), 314.021, 314.041(1)(a), 314.111(1), 314.131(1), (2)

STATUTORY AUTHORITY: KRS 314.041(1)(a), 314.111(1), 314.131(1), (2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.041(1)(a) requires that an applicant for licensure as a registered or licensed practical nurse complete the basic nursing curriculum in an approved school of nursing. KRS 314.111(1) requires that schools of nursing regardless of delivery models shall meet minimum standards and be approved by the Board of Nursing. KRS 314.131(1) and (2) authorizes the board to promulgate administrative regulations necessary to approve programs of nursing. This administrative regulation establishes the curriculum requirements for prelicensure registered nurse programs.

Section 1. Definitions. (1) "Associate degree program" means a program of nursing organized and administered by a community college, or a four (4) year college or university, which awards the graduate an associate degree in nursing upon meeting the requirements of the governing institution.

(2) "Baccalaureate degree program" means a program of nursing organized and administered by a senior college or university, which awards the graduate a baccalaureate degree in nursing upon meeting the requirements of the governing institution.

(3) "Master's[Masters]" degree program" means a program leading to a master's[masters] degree, which is the individual's first professional degree in nursing and is conducted by an educational unit in nursing within the structure of a senior college or university.

(4) "Multiple entry-exit program" [or "MEEP"] means a program that[which] allows a student to challenge the NCLEX-RN or NCLEX-PN examinations once[when] the student has completed sufficient course work in a professional nursing program that meets all requirements for the examination.

(5) "Practical nursing program" means a program of nursing organized and administered by a vocational, technical, or adult education system or an independent school at a postsecondary level that[which] awards the graduate a diploma in practical nursing upon meeting requirements of the program.

(6) "Prelicensure nursing education program" means an educational entity that offers the courses and learning experiences that prepare graduates who are competent to practice nursing

safely and who are eligible to take the NCLEX-RN or NCLEX-PN examinations.

(7) "Registered nursing program" means a program of nursing organized and administered by an institution of higher learning that[which] awards a degree upon meeting requirements of the program. A registered nursing program is considered to be any program that culminates in the graduate being eligible for licensure. Examples of registered nurse programs are associate degree programs, baccalaureate degree programs, master's[masters] degree programs, and multiple entry-exit programs.

Section 2. General. (1) An applicant for licensure shall complete a prelicensure program of nursing that meets the requirements of this administrative regulation.

(2) Length.

(a) A registered nursing program shall be a minimum of two (2) academic years, which may include prior articulated academic credits.

(b) A practical nursing program shall be a minimum of one (1) academic year.

(3) Philosophy, mission, and outcomes.

(a) The philosophy, mission, and outcomes of the program of nursing shall be clearly defined in writing by the nursing faculty and be consistent with those of the governing institution.

(b) The program outcomes shall describe the expected competencies of the graduate.

(c) The program shall conduct an assessment to validate that identified outcomes have been achieved and provide evidence of improvement based on an analysis of those results.

(d) The organizing framework shall serve as a foundation for level of progression, level of outcomes, and course sequencing.

(4) Approval.

(a) A curriculum plan shall be approved by the board in accordance with this administrative regulation.

(b) The curriculum plan shall enable the student to develop the nursing knowledge, skills, and competencies for the expected entry level and scope of practice.

(c) Theory and clinical experiences shall provide the student with opportunities to acquire and demonstrate the knowledge, skills, and competencies necessary for safe practice.

(5) Curriculum plan.

(a) The development, implementation, evaluation, and revision of the curriculum shall be the responsibility of the nursing faculty including the program administrator with input from students.

(b) The curriculum of the prelicensure nursing education program shall assure the development of evidence based practice for the level and scope of nursing practice. This shall include the skills to identify and apply best practices in nursing care by providing client-centered, culturally competent care and respecting client differences, values, preferences, and expressed needs.

(c) A registered nursing program may determine that a portion of the curriculum fulfills the scope of practice for licensed practical nursing and allow students to exit the program and be made eligible for the NCLEX-PN examination. The registered nursing program shall submit its plan to the board for approval.

(6) Organization of the curriculum.

(a) There shall be a written plan, including supporting rationale, and organizing framework, which describes the organization and development of the curriculum.

(b) The curriculum design shall reflect the philosophy, mission, and outcomes of the program.

(c) There shall be a rationale for the amount of time or credits allocated to course and clinical practice experience.

(d) A course syllabus shall be developed for each nursing course to include outcomes-planned[outcomes—planned] instruction, learning activities, and method of evaluation.

1. Each course shall be implemented in accordance with the established course syllabi.

2. A copy of each course syllabus shall be on file in the program of nursing office and shall be available to the board upon request.

(e) The curriculum plan shall be logical and[;] sequential, and

shall demonstrate an increase in difficulty and complexity as the student progresses through the program.

(7) Curriculum components.

(a) The curriculum of a registered nursing program or a practical nursing program shall prepare the graduate for licensure and full scope of practice as defined by ~~[law,]~~ current standards for nursing practice~~[,]~~ and expected competencies of graduates at the appropriate educational level.

(b) The curriculum shall include theory and selected clinical practice experiences designed to enable students to provide nursing care to individuals throughout the life span.

(c) Clinical practice settings shall be appropriate for the type of nursing program and the program outcomes and enable the student to observe and practice safe nursing care of persons at each stage of the life span. Experiences shall include opportunities to learn and provide care to diverse ethnic and cultural populations.

(d) Clinical practice experience shall be supervised by board approved nursing faculty in accordance with 201 KAR 20:310, including the utilization of clinical preceptors.

(e) The curriculum shall have written, measurable program competencies that reflect the role of the graduate.

(f) Students shall have sufficient opportunities in simulated or clinical settings to develop psychomotor skills essential for safe, effective practice.

(8) Curriculum change.

(a) A prelicensure nursing education program that is not accredited by a national nursing ~~accrediting~~~~[accrediting]~~ body shall submit a written plan for major curriculum revisions to the board a minimum of four (4) months prior to the planned implementation.

1. A request for curriculum revision shall include the present plan, the proposed change with rationale and expected outcomes.

2. The board shall be available to assist ~~if~~~~[when]~~ curriculum revisions are being considered.

3. Major curriculum revisions shall include:

~~a.[1.]~~ A change in the philosophy, mission or outcomes, which ~~results~~~~[result]~~ in a reorganization or re-conceptualization of the entire curriculum;

~~b.[2.]~~ The addition of tracks or alternative programs of study ~~that~~~~[which]~~ provide educational mobility; or

~~c.[3.]~~ The initiation of ~~on-line~~~~[distance]~~ learning ~~in~~~~[which/where]~~ a student may obtain fifty (50) percent or more of the nursing credits needed to meet program completion requirements.

(b) An accredited program of nursing shall submit to the board a copy of any curriculum revision submitted to an accrediting agency within thirty (30) days. The program of nursing shall submit a copy of all correspondence related to program accreditation from the accrediting agency to the board.

(c) A program of nursing that implements a curriculum change shall provide an evaluation of the outcomes of those changes through the first graduating class following full implementation of the curriculum change. The program of nursing shall also submit the evaluation with its annual report.

(9) Integrated practicum.

(a) The curriculum shall include an integrated practicum. The integrated practicum shall consist of a minimum of 120 clock hours of concentrated clinical experience of direct patient care in a health care facility or health care organization.

(b) The integrated practicum shall be completed within a period not to exceed seven (7) consecutive weeks while the governing institution is in session during the last semester or quarter of a nursing program.

~~[(10) All prelicensure nursing programs shall implement the integrated practicum requirement into their curriculum for students entering the program on or after July 1, 2004.](11)~~ Distance learning programs.

~~(a) A program of nursing that delivers didactic instruction by distance learning methods shall insure that the methods of instruction are compatible with the program curriculum and enables a student to meet the goals, competencies, and outcomes of the educational program and the standards set by the board.~~

~~(b) A distance learning program shall establish a means for~~

~~assessing individual student and program outcomes, including minimum student retention, student satisfaction, and faculty satisfaction.~~

~~(c) The nurse faculty shall be licensed in the state of origination of a distance learning program.~~

~~(d) A distance learning program shall provide students with access to technology, resources, technical support, and the ability to interact with peers and faculty.]~~

SALLY BAXTER, President

APPROVED BY AGENCY: October 17, 2013

FILED WITH LRC: November 14, 2013 at 4 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, January 13, 2014)**

201 KAR 20:390. Nursing Incentive Scholarship Fund.

RELATES TO: KRS 314.011, 314.025, 314.026, 314.027

STATUTORY AUTHORITY: KRS 314.026(1), 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.025 through 314.027 ~~authorize~~~~[create]~~ the Kentucky Nursing Incentive Scholarship Fund for Kentucky residents. KRS 314.026(1) requires the Board of Nursing to promulgate administrative regulations to implement and administer the scholarship fund. KRS 314.025 authorizes the Nursing Incentive Scholarship Fund to issue grants for nursing workforce competency development. This administrative regulation implements the Kentucky Nursing Incentive Scholarship Fund Program and establishes the requirements relating to the program. ~~[KRS 314.025 also allows the Nursing Incentive Scholarship Fund to issue grants for nursing workforce competency development.]~~ This administrative regulation ~~establishes~~~~[provides]~~ criteria for submitting grant requests.

Section 1. Definitions. (1) "Academic year" means:

~~a)[.]~~ For a registered nursing or graduate nursing program, a twelve (12) month period beginning with a fall session; and

~~b)~~ For a practical nursing program, the completion of the required program.

(2) "Board" is defined by KRS 314.011(1).

(3) "Committee" means the Kentucky Nursing Incentive Scholarship Fund Grant Review Committee.

(4) "Kentucky resident" is defined by 13 KAR 2:045, Section ~~1(10)~~~~[1(1)]~~.

(5) "Program of nursing" means ~~[either]~~ a prelicensure, BSN completion, or graduate nursing program.

(6) "Successful academic progression" means, except during the last academic year preceding graduation.

(a) For a prelicensure or BSN completion nursing program, the completion of a minimum of fifteen (15) credit hours per academic year of published requirements for the program of nursing and maintenance of a minimum grade point average which would allow continuation in a program of nursing; or

(b) For a graduate nursing program, the completion of a minimum of nine (9) credit hours per academic year of published requirements for the program of nursing and maintenance of a minimum grade point average which would allow continuation in the graduate program.

~~[(c) The provisions of paragraphs (a) and (b) of this subsection shall not apply during the last academic year preceding graduation.]~~

Section 2. Application. (1) To be eligible for a nursing incentive scholarship, an applicant shall:

(a) Be a Kentucky resident; and

(b) Have been accepted for admission to a program of nursing.

(2) An applicant shall submit a completed ~~["Nursing Incentive Scholarship Application"]~~ by June 1 to apply for a scholarship for the following academic year.

(3) An applicant shall attach to the Nursing Incentive Scholarship Application a copy of the Student Aid Report from the Free Application for Federal Student Aid (FAFSA) for the current year, if requesting preference for financial need.

Section 3. The Committee. (1) A member of the committee shall serve for two (2) years and may be reappointed.

(2) The committee shall meet as needed to review grant requests submitted pursuant to Section 11 of this administrative regulation.

(3) A member of the committee shall:

- (a) Serve without compensation; and
- (b) Be reimbursed for actual and necessary expenses related to serving on the committee.

Section 4. Criteria for Awards. The board shall consider the following criteria in evaluating an application and shall award points as follows:

(1) Preference categories as specified in KRS 314.025(2):

- (a) Licensed practical nurses, twenty-five (25) points;
- (b) Registered nurses pursuing graduate nursing education, twenty-five (25) points; and
- (c) Financially-needy Kentucky residents, twenty-five (25) points. Financial need shall be determined by the annual FAFSA Pell Grant Indicator of Eligibility for Financial Aid.

(2) Potential for academic success, as follows: high school, vocational school, college, or university grade point average for whichever institution the applicant most recently attended:

- (a) Three and five-tenths (3.5) to four (4.0), twenty-five (25) points;
- (b) Three (3) to three and four-tenths (3.4), twenty (20) points; and
- (c) Two and five-tenths (2.5) to two and nine-tenths (2.9), fifteen (15) points.

(3) Previous health care experience, either paid or volunteer, shall be equal to five (5) points for each year in which service is validated, to a maximum of twenty-five (25) points.

Section 5. Amount of Award. (1) The board shall be notified by the board's fiscal officer as to the current fund balance prior to making an award.

(2)(a) The board shall first make awards to those recipients who:

- 1. Received an award in the previous year; and
- 2. Remain eligible to receive an award pursuant to Section 7 of this administrative regulation in the current year.

(b) If funds remain available after the awards are made pursuant to paragraph (a) of this subsection, the board shall make an award to other eligible applicants.

Section 6. Procedure for Disbursement of Awards. (1) Disbursement of funds shall be made directly to the recipient.

(2) Disbursement shall be made annually.

(3) Each educational institution in which a student receiving a nursing incentive scholarship award is enrolled shall certify to the board no later than thirty (30) days from the beginning of each semester, that the recipient:

- (a) Has enrolled; and
- (b) Is in good standing in the nursing program.

Section 7. Continuing Eligibility Criteria. (1) A recipient of a nursing incentive scholarship shall be eligible to continue to receive an award if the recipient:

(a) Maintains successful academic progression through the program; and

(b) Submits to the board a completed ~~["Nursing Incentive Scholarship Fund Application"]~~ form by June 1.

(2) The educational institution shall immediately notify the board of a change in a recipient's enrollment status.

(3) An award recipient in a practical nursing program shall not

be eligible for further awards from the Nursing Incentive Scholarship Fund while enrolled in that program.

Section 8. Disbursement Contract. (1) Prior to disbursement of initial funds, the recipient shall sign a ~~["Nursing Incentive Scholarship Fund Contract"]~~.

(2) The recipient shall sign a ~~["Nursing Incentive Scholarship Fund Promissory Note"]~~ for each year in which funds are disbursed.

Section 9. Repayment and Deferral. (1) A recipient shall immediately become liable to the board to pay the sum of all scholarships received and the accrued interest on the scholarships if the recipient fails to complete the:

- (a) Nursing program in which he or she is enrolled within the time specified by the program of nursing; or
- (b) Required employment as specified in the contract.

(2) Written notification of demand for repayment shall be sent by the board to the scholarship recipient's last known address and shall be effective upon mailing.

(a) The board may agree, in its sole discretion, to accept repayment in installments in accordance with a schedule established by the board.

(b) Payments shall first be applied to interest and then to principal on the earliest unpaid contracts.

(3) Repayment may be deferred in the case of disability, major illness, or accident ~~that~~which prevents a recipient from completing a program of nursing or being employed as a nurse in Kentucky.

(4) A student enrolled in a program of nursing may defer repayment if the student fails to achieve successful academic progression.

(a) This deferment shall apply for one (1) academic year.

(b) If the student fails to achieve successful academic progression after that time, repayment shall be due.

(c) If the student achieves successful academic progression within the allotted time, he or she may apply for a continuation award pursuant to Section 7 of this administrative regulation.

(5)(a) If a deferment is requested, the recipient shall submit the request to the board on a ~~["Nursing Incentive Scholarship Fund Request for Deferment"]~~ form.

(b) If the request for deferment is submitted pursuant to subsection (3) of this section, the Nursing Incentive Scholarship Fund Request for Deferment form shall be accompanied by a physician's statement.

(6) If a recipient fails to pass the licensure examination within two (2) years of graduation, the sum of all nursing incentive scholarships received by the recipient, and the accrued interest, shall become due and payable.

(7) ~~If~~When a court of competent jurisdiction determines that the recipient has defaulted and the funds are due and owing to the board, then the provisions of 201 KAR 20:370, Section 1(5), shall apply.

(8) An individual who has defaulted on a scholarship shall not be eligible to receive another scholarship until the defaulted scholarship has been repaid.

Section 10. Verification. (1) Verification of employment as a nurse in Kentucky pursuant to the contract shall be submitted to the board when the recipient's employment commitment begins and when it is completed. A termination of employment prior to completion shall be reported to the board within thirty (30) days by the employer and the recipient.

(2) A recipient shall notify the board immediately of a change of name or address or enrollment status in school.

Section 11. Grant Requests. (1) ~~[No]~~More than forty (40) percent of available revenues received from fines levied by the Cabinet for Health and Family Services shall not be expended for grants in any given year.

(2) The deadline for grant requests shall be May 1 and November 1 annually.

(3) The grant request shall include~~[the following]~~:

(a) A problem statement or purpose related to improving nursing workforce competency;

(b) The proposed workforce development activity and how it has general applicability to the entire nursing workforce in the state;

(c) The proposed timelines and outcomes;

(d) The outcome measurement criteria to be used;

(e) The amount requested with a supporting budget;

(f) Any matching or in kind budget contributions to be received; and

(g) The preferred funding cycle of either all funds given initially or partial funds given initially and the remainder at specified intervals.

(4) The following shall be/are the reporting requirements for grants that are funded:

(a) An initial report shall be submitted to the board six (6) months following funding or at the midpoint of the grant timeline if that is sooner than six (6) months from the funding date or as directed by the board.

(b) Interim reports shall be submitted at six (6) month intervals or as required by the board for the duration of the project funded.

(c) A final report shall be submitted to the board within three (3) months of completion of the project. The final report shall document outcome achievements and their relationship to the funds spent.

(5) Any money that is unused for the purpose of the grant shall be returned to the fund, unless otherwise directed by the board.

Section 12. Incorporation by Reference. (1) The following forms are incorporated by reference:

(a) "Nursing Incentive Scholarship Fund Application," ~~[(12/01)P-7]~~;

(b) "Nursing Incentive Scholarship Fund Request for Deferral," ~~[(10/96)P-7]~~;

(c) "Nursing Incentive Scholarship Fund Contract," ~~[(10/13) [(10/96)P-7]]~~; and

(d) "Nursing Incentive Scholarship Fund Promissory Note," ~~[(10/13) [(10/96)P-7]]~~.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, Monday through Friday, 8:30 a.m. to 4:30 p.m.

SALLY BAXTER, President

APPROVED BY AGENCY: October 17, 2013

FILED WITH LRC: November 14, 2013 at 4 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.

**TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(As Amended at ARRS, January 13, 2014)**

301 KAR 2:221. Waterfowl seasons and limits.

RELATES TO: KRS 150.010(40), 150.025(1), 150.305(1), 150.330, 150.340(1), (3), 150.990

STATUTORY AUTHORITY: KRS 150.025(1), 150.360, 150.600(1), 50 C.F.R. 20, 21

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish open seasons for the taking of wildlife and to regulate bag limits. KRS 150.360 authorizes the department to restrict methods of taking wildlife. KRS 150.600(1) authorizes the department to regulate the taking of waterfowl on public and private land. This administrative regulation establishes procedures for the taking of waterfowl within reasonable limits and within the frameworks established by 50 C.F.R. Parts 20 and 21.

Section 1. Definitions. (1) "Dark goose" means a Canada goose,

white-fronted goose, or brant.

(2) "Light Goose" means a snow goose or Ross's goose.

(3) "Light Goose Conservation Order" is defined by 50 C.F.R. 21.60

(4) "Waterfowl" is defined by/in KRS 150.010(40).

Section 2. (1) Except as authorized by 301 KAR 2:222, 2:225, or 2:226, a person shall not hunt waterfowl except during the seasons established in this administrative regulation.

(2) Hunting zones, special hunt areas and reporting areas are established in 301 KAR 2:224.

Section 3. Season dates. (1) Duck, coot, and merganser:

(a) Beginning on Thanksgiving Day for four (4) consecutive days; and

(b) For fifty-six (56) consecutive days ending on the last Sunday in January of the following year.

(2) Canada goose:

(a) Eastern, Pennyryle, and Western Goose Zones, beginning on Thanksgiving Day and continuing until the last day in January.

(b) Northeast Goose Zone: ~~[(10/96)P-7]~~ Beginning on January 1 for thirty-one (31) consecutive days.

(3) White-fronted and brant geese, beginning on Thanksgiving Day and continuing until the last day in January.

(4) Light goose:

(a) Beginning on Thanksgiving Day and continuing until the last day in January; and

(b) Light Goose Conservation Order season:

1. Western Duck Zone: from February 1 through March 31, except:

a. The season shall be closed during the first full weekend in February; and

b. Youth hunters may hunt during the first full weekend in February pursuant to 301 KAR 2:226.

2. Eastern Duck Zone from February 1 through March 31.

(5) A person shall not hunt a light or dark goose in:

(a) The areas of Laurel River Lake as posted by sign; or

(b) Cave Run Lake and the public land inside the boundary formed by Highways 801, 1274, 36, 211, US 60, and Highway 826.

Section 4. In the Ballard Zone that is established in 301 KAR 2:224:

(1) A person hunting waterfowl shall:

(a) Hunt from a blind unless hunting in flooded, standing timber;

(b) Not hunt from or establish a blind:

1. Within 100 yards of another blind; or

2. Within fifty (50) yards of a property line; and

(c) Not possess more than one (1) shotgun while in a blind.

(2) The requirements of subsection (1) of this section shall not apply if the Light Goose Conservation Order, as established in 301 KAR 2:221, is the only waterfowl season open, excluding falconry seasons.

Section 5. Bag and Possession Limits. (1) Ducks: The daily limit shall be six (6), that shall not include more than:

(a) Four (4) mallards;

(b) Two (2) hen mallards;

(c) Three (3) wood ducks;

(d) One (1) black duck;

(e) Two (2) redheads;

(f) Two (2) pintails;

(g) ~~Three (3)~~ ~~Four (4)~~ scaup;

(h) One (1) mottled duck; or

(i) ~~Two (2)~~ ~~One (1)~~ canvasback.

(2) Coot: Daily limit fifteen (15).

(3) Merganser: Daily limit five (5), which shall not include more than two (2) hooded mergansers.

(4) Dark goose: Daily limit five (5), that shall not include more than:

(a) ~~Three (3)~~ ~~Two (2)~~ Canada geese;

(b) Two (2) white-fronted geese; or

(c) One (1) brant.

(5) Light goose: Daily limit twenty (20), except that there shall not

be a limit during the Light Goose Conservation Order season.

(6) The possession limit shall be ~~triple~~~~[double]~~ the daily limit, except that there shall not be a light goose possession limit.

Section 6. Shooting Hours. A person shall not hunt waterfowl except from one-half (1/2) hour before sunrise until:

(1) 2 p.m. if hunting geese in the Northeast Goose Zone during a Canada goose season;

(2) Sunset in the remainder of the state, except as established[specified] in 301 KAR 2:222; or

(3) One-half (1/2) hour after sunset if hunting light geese during the Light Goose Conservation Order season.

Section 7. Falconry Waterfowl Season and Limits. (1) Season dates:

(a) Light goose: November 5 through January 31;

(b) Light Goose Conservation Order season:

1. Western Duck Zone: from February 1 through March 31, except:

a. The season shall be closed during the first full weekend in February; and

b. Youth hunters may hunt during the first full weekend in February pursuant to 301 KAR 2:226.

2. Remainder of state: from February 1 through March 31; and

(c) Other waterfowl: November 5 through January 31.

(2) Daily limit: three (3) waterfowl, except that there shall not be a limit on light goose during the Light Goose Conservation Order season.

(3) Possession limit: six (6) waterfowl, except that there shall not be a possession limit on light goose during the Light Goose Conservation Order season.

Section 8. Permit for the Light Goose Conservation Order season. (1) A person hunting light goose during the Light Goose Conservation Order season shall first obtain a free permit by completing the online Snow Goose Conservation Order Permit[application] process on the department's Web site at fw.ky.gov.

(2) A person hunting light goose during the Light Goose Conservation Order season shall submit a Snow Goose Conservation Order Permit Survey[Light Goose Conservation Order report] to the department by April 10.

Section 9. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Snow Goose Conservation Order Permit", January 2014; and

(b) "Snow Goose Conservation Order Permit Survey", January 2014.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Fish and Wildlife Resources, #1 Game Farm Road, Frankfort, Kentucky, 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

BENJY KINMAN, Deputy Commissioner

ROBERT H. STEWART, Secretary

APPROVED BY AGENCY: October 2, 2013

FILED WITH LRC: October 21, 2013 at 2 p.m.

CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman's Lane, Frankfort, Kentucky 40601, phone (502) 564-3400, fax (502) 564-9136, email fwpubliccomments@ky.gov.

**TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(As Amended at ARRS, January 13, 2014)**

301 KAR 2:222. Waterfowl hunting requirements on public lands.

RELATES TO: KRS 150.010(40), 150.305(1), 150.330,

150.340(1), (3), 150.990

STATUTORY AUTHORITY: KRS 150.025(1), 150.360, 150.600(1), 50 C.F.R. 20, 21

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish open seasons for the taking of wildlife and to regulate bag limits. KRS 150.360 authorizes the department to restrict methods of taking wildlife. KRS 150.600(1) authorizes the department to regulate the taking of waterfowl on public and private land. This administrative regulation establishes procedures for the taking of waterfowl within reasonable limits and within the frameworks established by 50 C.F.R. Parts 20 and 21.

Section 1. Definitions. (1) "Blind" means a:

(a) Concealed enclosure;

(b) Pit; or

(c) Boat.

(2) "Department blind" means a permanently fixed blind structure built by the department.

(3) "Hunt site" means a specific location where waterfowl hunting is allowed, as approved by the department or the U.S. Army Corps of Engineers.

(4) "Layout blind" means a portable blind that when fully deployed allows one (1) person to be concealed above the surface of the ground.

(5) "Party" means:

(a) A person hunting alone; or

(b) Two (2) to four (4) people who share a department blind or hunt site.

(6) "Permanent blind" means a blind left in place by a waterfowl hunter longer than twenty-four (24) hours.

(7) "Regular waterfowl season" means the open waterfowl season that does not include the Light Goose Conservation Order or the September wood duck, teal, and Canada goose seasons as established in 301 KAR 2:221 and 2:225.

(8) "Waterfowl" is defined by/in KRS 150.010(40).

(9) "Wildlife Management Area" or "WMA" means a tract of land:

(a) Controlled by the department through ownership, lease, license, or cooperative agreement; and

(b) That has "Wildlife Management Area" or "WMA" as part of its official name.

Section 2. Shot requirements. A person hunting waterfowl shall not use or possess a shotgun shell:

(1) Longer than three and one-half (3 1/2) inches; or

(2) Containing:

(a) Lead shot;

(b) Shot not approved by the U.S. Fish and Wildlife Service for waterfowl hunting; or

(c) Shot larger than size "T".

Section 3. (1) Except as established[specified] in this section or in Section 4 of this administrative regulation, on a Wildlife Management Area:

(a) A person hunting waterfowl shall not:

1. Establish or hunt from a permanent waterfowl blind;

2. Hunt within 200 yards of:

a. Another occupied hunt site;

b. Another legal waterfowl hunting party; or

c. An area closed to waterfowl hunting;

(b) A person shall not hunt in a designated recreation area or access point;

(c) More than four (4) persons shall not occupy a waterfowl blind or hunt site; and

(d) A hunter shall remove decoys and personal items daily, except that a hunter drawn for a multiday hunt may choose to leave decoys in place for the duration of the hunt.

(2) In order~~[A person wanting]~~ to establish or use a permanent waterfowl blind or hunt site on Lake Barkley, Barren River Lake, Buckhorn Lake, Green River Lake, Nolin River Lake, Paintsville Lake, Rough River Lake, Sloughs, or Doug Travis Wildlife Management Areas, a person:

- (a) Shall first obtain a waterfowl blind permit from the U.S. Army Corps of Engineers or the department;
- (b) May designate one (1) other person as a partner; and
- (c) Shall not hold more than one (1) permit per area.
- (3) A person who participates in a drawing for a hunt site permit shall:

- (a) Be at least eighteen (18) years of age; and
- (b) Possess:
 - 1. A valid Kentucky hunting license;
 - 2. A Kentucky waterfowl permit; and
 - 3. A federal duck stamp.
- (4) The holder of a hunt site permit shall:
 - (a) Construct or establish the blind or hunt site before November 20 or forfeit the permit;
 - (b) Not lock a waterfowl blind; and
 - (c) Remove the blind and blind materials within thirty (30) days after the close of the regular waterfowl season or be ineligible for a permit the following year, unless an extension of time is granted by the department based on weather or water level conflicts.
 - (5) A permanent blind, department blind, or blind site not occupied by the permit holder one (1) hour before sunrise shall be available to another hunter on a first-come, first-served basis.
 - (6) A waterfowl blind restriction established in this section shall not apply to a falconer if a gun or archery season is not open.

Section 4. Wildlife Management Area Requirements. (1) The regular waterfowl season provisions shall apply, as established in 301 KAR 2:221, except as established in this section.

(2) The provisions of this section shall not apply to a waterfowl hunting season that opens prior to October 15, as established in 301 KAR 2:225.

- (3) A person shall not:
 - (a) Hunt on an area marked by a sign as closed to hunting;
 - (b) Enter an area marked by signs as closed to public access; or

(c) Hunt a species on an area marked by signs as closed to hunting for that species.

- (4) On Wildlife Management Areas in Ballard County:
 - (a) The shotgun shell possession limit shall be fifteen (15), except that the shotgun shell possession limit shall be twenty-five (25) if:
 - 1. The daily bag limit for ducks is greater than three (3); and
 - 2. The daily bag limit for Canada goose is greater than or equal to two (2); and[-]

(b) At least one (1) person in a waterfowl blind shall be eighteen (18) years of age or older if hunting in a department waterfowl blind or hunt site at Ballard or Boatwright WMA.

- (5) At Ballard WMA:
 - (a) The duck, coot, merganser, and goose season shall be the first Wednesday in December[5] through the last Sunday in January[27];
 - (b) Youth waterfowl season shall be the first full weekend in February;

(c) A person hunting waterfowl shall not hunt on Monday, Tuesday, Christmas Day, or New Year's Day; and

- (d) A person hunting waterfowl shall:
 - 1. Apply for the waterfowl quota hunt as established in Section 5 of this administrative regulation;

2. Not hunt waterfowl on the Ohio River from fifty (50) yards upstream of Dam 53 to fifty (50) yards downstream from the southern border of Ballard Wildlife Management Area from October 15 through March 15; and

3. Exit the area by 2 p.m. during the regular waterfowl season, except as authorized by the department.

(6) At Boatwright WMA, including the Olmsted, Peal, and Swan Lake units:

- (a) A party shall:
 - 1. Not hunt on Monday, Tuesday, Christmas Day, or New Year's Day;
 - 2. Obtain a daily check-in card by 8 a.m. before entering the area from the first Wednesday in December[5] through the last Sunday in January[27]; and
 - 3. Check out the same day by:

- a. Visiting the designated Check station prior to 8 a.m.; or
- b. Depositing the check-in card at a department-designated drop point after 8 a.m.;

(b) Duck season shall be open one-half (1/2) hour before sunrise to sunset beginning Thanksgiving Day for four (4) consecutive days on areas of Boatwright WMA that are open to hunting;[-]

(c) A department blind or hunt site shall be assigned through a daily drawing through the last Sunday in January[-];[27-]

(d) A department blind or hunt site shall be offered to another hunter on a first-come, first-served basis, if the blind or hunt site has not been assigned during the daily drawing;[-]

(e) Waterfowl hunters shall exit the area by 2 p.m. during the regular waterfowl season;[-]

- (f) A boat blind shall not be permitted in flooded timber, except:
 - 1. During periods of flood if no other access is possible; or
 - 2. A mobility-impaired hunter may hunt from a boat;[-]

(g) A party shall only hunt waterfowl:

- 1. From a department blind; or
- 2. From layout blinds set so that all layout blinds in the party lie within a twenty-five (25) foot radius from the center of the party, and within 200 yards of a hunt site in December and January during the regular waterfowl season;[-]

(h) On the Peal unit:

- 1. More than seven (7) parties shall not hunt at the same time on Buck Lake or Flat Lake;
- 2. More than four (4) parties shall not hunt at the same time on Fish Lake;

3. More than three (3) parties shall not hunt at the same time on First Lake or Second Lake; and

4. A party shall not hunt waterfowl except within twenty-five (25) feet of a hunt site during December and January; and[-]

(i) On the Swan Lake Unit:

- 1. A person shall not hunt waterfowl from Thanksgiving Day[November 22] through the first Tuesday in December [4];

2. The area open to hunting during the regular waterfowl season shall be open for the Light Goose Conservation Order season as established in 301 KAR 2:221; and

3. Blind restrictions shall not apply to the Light Goose Conservation Order season.

(7) Lake Barkley WMA.

- (a) A permanent blind shall only be established within ten (10) yards of a blind site;[-]

(b) Waterfowl refuge areas shall be:

- 1. The area west of the Cumberland River channel, as marked by buoys, between river mile fifty-one (51), at Hayes Landing Light, south to the Tennessee Valley Authority's power transmission lines at river mile fifty-five and five-tenths (55.5) shall be closed from November 1 through February 15; and

2. The area within Honker Bay and Fulton Bay, as marked by buoys and signs, shall be closed from November 1 through March 15.

(c) A person shall not hunt from October 15 through March 15:

- 1. On Duck Island; or
- 2. Within 200 yards of Duck Island.

(8) Barren River Lake WMA. A person hunting waterfowl:

- (a) May use a breech-loading shotgun along the shoreline of the Peninsula Unit; and
- (b) Shall not use a breech-loading firearm elsewhere on the area.

(9) Miller Welch-Central Kentucky WMA. A person shall not hunt waterfowl from October 15 through January 14.

(10) Lake Cumberland WMA. The following sections shall be closed to the public from October 15 through March 15:

(a) The Wesley Bend area, bounded by Fishing Creek, Beech Grove Road and Fishing Creek Road; and

(b) The Yellowhole area, bounded by Fishing Creek Road and Hickory Nut Road.

(11) Pioneer Weapons WMA. A person hunting waterfowl:

- (a) May use a breech-loading shotgun along the shoreline of Cave Run Lake; and
- (b) Shall not use a breech-loading firearm elsewhere on the area.

- (12) Doug Travis WMA.
 (a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
 (b) A person shall not enter a hunting area prior to 4 a.m. daily.
 (c) A person hunting waterfowl shall exit the area by 2 p.m. during waterfowl season, except as authorized by the department.
 (d) On Black Lake, Fish Lake, Forked Lake, Indian Camp Lake, Number Four Lake, and Upper Goose Lake, all waterfowl hunting after November 1:
 1. Shall be from hunt sites assigned by a random preseason drawing; and
 2. Shall be within ten (10) yards of a hunt site, including periods of Mississippi River flooding.
 (13) Grayson Lake WMA. A person shall not hunt waterfowl:
 (a) Within the no-wake zone at the dam site marina;
 (b) From the shore of Camp Webb;
 (c) On Deer Creek Fork; ~~or~~[and]
 (d) Within three-quarters (3/4) of a mile from the dam.
 (14) Green River Lake WMA.
 (a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
 (b) A person shall not enter a hunting area prior to 4 a.m. daily.
 (15) Kaler Bottoms WMA.
 (a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
 (b) A person shall not enter a hunting area prior to 4 a.m. daily.
 (16) Land Between the Lakes National Recreation Area.
 (a) The following portions shall be closed to the public from November 1 through March 15:
 1. Long Creek Pond;
 2. The eastern one-third (1/3) of Smith Bay, as marked by buoys; and
 3. The eastern two-thirds (2/3) of Duncan Bay, as marked by buoys;
 (b) The following portions shall be closed to waterfowl hunting:
 1. The Environmental Education Center; and
 2. Energy Lake.
 (c) A person shall possess an annual Land Between the Lakes Hunting Permit if hunting waterfowl:
 1. Inland from the water's edge of Kentucky Lake or Barkley Lake; or
 2. From a boat on a flooded portion of Land Between the Lakes when the lake level is above elevation 359.
 (d) A person shall not hunt waterfowl on inland areas during a quota deer hunt.
 (e) A person shall not establish or use a permanent blind:
 1. On an inland area; or
 2. Along the Kentucky Lake shoreline of Land Between the Lakes.
 (f) A person hunting waterfowl shall remove decoys and personal items daily.
 (17) Obion Creek WMA.
 (a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
 (b) A person shall not enter a hunting area prior to 4 a.m. daily.
 (18) Ohio River Islands WMA.
 (a) A person shall not hunt from October 15 through March 15 on the Kentucky portion of the Ohio River from Smithland Lock and Dam upstream to the power line crossing at approximately river mile 911.5.
 (b) Stewart Island shall be closed to public access from October 15 through March 15.
 (c) Shooting hours shall be one-half (1/2) hours before sunrise until 2 p.m.
 (d) A person shall not enter a hunting area prior to 4 a.m. daily.
 (19) Peabody WMA.
 (a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
 (b) A person shall not enter a hunting area prior to 4 a.m. daily.
 (c) The following areas, as posted by signs, shall be closed to the public from October 15 through March 15:
 1. The Sinclair Mine area, bounded by Hwy 176, the haul road, and Goose Lake Road; and

2. The Ken area, bounded by Wysox Road, H2 Road, H1 Road, and H6 Road.
 (20) Robinson Forest WMA. The main block of the WMA shall be closed to waterfowl hunting.
 (21) Sloughs WMA.
 (a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
 (b) A person shall not enter a hunting area prior to 4 a.m. daily.
 (c) A person hunting waterfowl shall exit the area by 2 p.m. during the regular waterfowl season.
 (d) On the Grassy-Pond Powell's Lake Unit, a person hunting waterfowl:
 1. Shall hunt:
 a. From a department blind; or
 b. From a blind within twenty-five (25) yards of a blind site; ~~and~~;
 2. Shall remove decoys and personal items from the area on a daily basis.
 (e) On the Jenny Hole-Highlands Creek Unit, a person hunting waterfowl ~~shall~~:
 1. ~~[Shall]~~ Hunt:
 a. From a department blind;
 b. Within twenty-five (25) yards of a hunt site; or
 c. No closer than 200 yards of another hunting party; ~~and~~;
 2. ~~[Shall]~~ Remove decoys and personal items from the area on a daily basis.
 (f) If the Ohio River reaches a level that requires boat access, a waterfowl hunter:
 1. May hunt from a boat without regard to department blinds; and
 2. Shall not hunt closer than 200 yards from another boat.
 (g) ~~If a person~~ hunting waterfowl on the Crenshaw and Duncan Tracts of the Sauerheber Unit:
 1. A person shall hunt from a blind assigned by the department through a drawing as established in Section 5 of this administrative regulation;
 2. A person may occupy a permitted blind if not claimed by the permittee within one (1) hour before sunrise;
 3. A person shall not possess more than fifteen (15) shotgun shells, except that the shotgun shell possession limit shall be twenty-five (25) if:
 a. The daily bag limit for ducks is greater than three (3); and
 b. The daily bag limit for Canada goose is greater than or equal to two (2);
 4. If under eighteen (18) years of age, a person shall be accompanied by an adult ~~[if under eighteen (18) years of age]~~; and
 5. The waterfowl blind for a mobility-impaired person shall be open to the public if the permit holder or another mobility-impaired person has not claimed the blind on that day by one (1) hour before sunrise.
 (h) The Crenshaw and Duncan II tracts of the Sauerheber Unit shall be closed to hunting except for:
 1. Waterfowl from November 1 through March 15; and
 2. The modern gun deer season.
 (i) The remainder of the Sauerheber Unit shall be closed to the public from November 1 through March 15.
 (j) A hunter drawn to hunt Sloughs WMA through a preseason draw shall submit a completed Sloughs WMA Waterfowl Hunter Survey Report ~~[department-issued survey]~~ at the conclusion of the hunt or shall be ineligible to participate in the waterfowl blind or quota draw the following year.
 (22) South Shore WMA.
 (a) The WMA shall be closed to hunting from November 15 through January 15, except for waterfowl and dove hunting.
 (b) A hunter shall use a department blind.
 (c) A department blind shall be available daily on a first-come, first-served basis.
 (23) Taylorsville Lake WMA.
 (a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.
 (b) A person shall not enter a hunting area prior to 4 a.m. daily.
 (24) Yatesville Lake WMA. The following areas shall be closed

to waterfowl hunting, unless authorized by Yatesville Lake State Park:

- (a) The Greenbrier Creek embayment; and
- (b) The lake area north from the mouth of the Greenbrier Creek embayment to the dam, including the island.

(25) Yellowbank WMA. The area designated by a sign and painted boundary marker shall be closed to the public from October 15 through March 15.

(26) Cedar Creek WMA.

(a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.

(b) A person shall not enter a hunting area prior to 4 a.m. daily.

(27) Dix River WMA.

(a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.

(b) A person shall not enter a hunting area prior to 4 a.m. daily.

(28) J.C. Williams WMA.

(a) Shooting hours shall be one-half (1/2) hour before sunrise until 2 p.m.

(b) A person shall not enter a hunting area prior to 4 a.m. daily.

Section 5. Ballard WMA and Sloughs WMA. (1) A person applying to hunt waterfowl on Ballard WMA or the Sauerheber Unit of Sloughs WMA shall:

(a) Apply[through the vendor supplied by the department] by:
1. Calling[calling] 1-877-598-2401 and completing the telephone application process[;] or[by]

2. Completing[completing] the online Ballard or Sloughs Waterfowl Quota Hunt Form[application] process on the department's Web site at fw.ky.gov;

(b) Apply from September 1 through September 30;

(c) Pay a three (3) dollar application fee for each application; and

(d) Not apply more than one (1) time for each hunt.

(2) A person drawn to hunt may bring up to three (3) additional hunters.

(3) A person shall be declared ineligible to hunt in department waterfowl quota hunts during the remaining portion of the waterfowl season and declared ineligible to apply for any department quota hunt the following year if the hunter violates state or federal regulations while waterfowl hunting on WMAs that have a preseason or daily drawing.

Section 6. State Parks. (1) Waterfowl hunting shall be prohibited, except there shall be an open waterfowl hunt December 13 through January 31 on designated areas of state parks at:

(a) Barren River[;]

(b) Grayson Lake[;]

(c) Greenbo Lake[;]

(d) Lake Barkley[;]

(e) Lincoln Homestead[;]

(f) Nolin Lake[;]

(g) Paintsville Lake[;]

(h) Pennyriple Lake[;]

(i) Rough River Lake[;] and

(j) Yatesville Lake[State Parks].

(2) Hunters shall check in each day at the front desk of the state park or a designated check-in location on days that the park office is not open.

(3) During check-in hunters shall be provided a map showing designated areas of the park that are open to waterfowl hunting.

(4) Hunters shall check out each day at the front desk of the state park or a designated check-out location on days that the park office is not open. ~~[(5) Statewide waterfowl hunting requirements shall apply.]~~

Section 7. Youth-Mentor and Mobility-Impaired Waterfowl Hunts. (1) There shall be youth-mentor waterfowl hunts on the Minor Clark and Peter W. Pfeiffer fish hatcheries each Saturday and Sunday in January.

(2) There shall be a mobility-impaired waterfowl hunt at Minor Clark Fish Hatchery that is held concurrently with each youth-mentor hunt.

(3) A youth or mobility-impaired person shall register in advance and carry a department provided postcard notification on the day of the hunt.

(4) A mobility-impaired person shall also submit a mobility-impaired access permit pursuant to 301 KAR 3:026.

(5) Each youth shall be accompanied by an adult who is eighteen (18) years or older.

(6) Each youth shall not be accompanied by more than one (1) adult.

(7) One (1) adult may accompany two (2) youths.

(8) A mobility-impaired hunter may be accompanied by no more than one (1) assistant who may also hunt.

(9) A person:

(a) Shall hunt from an established blind; and

(b) Shall not change blinds.

(10) A blind shall not be used by more than four (4) hunters.

(11) A person shall only discharge a firearm from a blind.

(12) A person shall not possess more than fifteen (15) shotshells.

(13) A waterfowl hunter, mentor, or assistant shall immediately retrieve downed birds.

(14) A person shall encase a firearm if traveling to and from a blind.

(15) A hunter shall:

(a) Cease hunting by[Hunting shall end at] noon[;] and

(b) Exit[hunters shall exit] the area by 1 p.m.

(16) All decoys and equipment shall be removed at the end of each day's hunt.

(17) A hunter shall report harvest by depositing a completed hunt permit at the designated location.

Section 8. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Sloughs WMA Waterfowl Hunter Survey Report", January 2014; and

(b) "Ballard or Sloughs Waterfowl Quota Hunt Form", January 2014.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Fish and Wildlife Resources, #1 Game Farm Road, Frankfort, Kentucky, 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

BENJY KINMAN, Deputy Commissioner

ROBERT H. STEWART, Secretary

APPROVED BY AGENCY: October 2, 2013

FILED WITH LRC: October 21, 2013 at 2 p.m.

CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman's Lane, Frankfort, Kentucky 40601, phone (502) 564-3400 fax (502) 564-9136, email fwpubliccomments@ky.gov.

**GENERAL GOVERNMENT CABINET
Department of Agriculture
Office of Consumer and Environmental Protection
Division of Environmental Services
(As Amended at ARRS, December 10, 2013)**

Compiler's Note: This administrative regulation was amended at the December 2013 ARRS meeting, and then was deferred as amended for review at the January 2014 ARRS meeting. It is being published in this month's Register following completion of the ARRS review.

302 KAR 21:001. Definitions for 302 KAR Chapter 21.

RELATES TO: KRS 246.420, 256.010, 257.160, 257.196, 525.130, 7 U.S.C. 2131-2159

STATUTORY AUTHORITY: KRS 257.196

NECESSITY, FUNCTION, AND CONFORMITY: KRS 257.196 requires the Board of Agriculture to promulgate administrative regulations establishing on-farm livestock and poultry care

standards recommended to it by the Kentucky Livestock Care Standards Commission. This administrative regulation establishes the definitions for 302 KAR Chapter 21.

Section 1. Definitions. (1) "Ambulatory disabled" means being capable of walking, but with a physical impairment that severely limits or threatens the ability to walk.

(2) "Distress" means a condition that occurs when livestock or poultry are injured, sick, or in physical pain.

(3) "Euthanasia" means the act of putting an animal to death by methods specified as acceptable for that species by the 2007 Report of the American Veterinary Medical Association (AVMA) Panel on Euthanasia, incorporated by reference in 302 KAR 21:020.

(4) "Handling" means the moving or confining of livestock or poultry for management practices, relocating, loading, or unloading.

(5) "Housing" means space used to shelter or confine livestock and poultry.

(6) "Management practices" means procedures in livestock and poultry production to improve animal health, reproduction, comfort, safety, productivity, and product acceptability.

(7) "Non-ambulatory disabled" means being unable to rise from a recumbent position or being unable to walk.

(8) "Responsible party" means a person who is the owner of the livestock or poultry or a person who has current responsibility of custody of the livestock or poultry.

(9) "Soring" means:

(a) 1. An irritating or blistering agent has been applied, internally or externally, by a person to a limb of a horse;

2. [(b)] A burn, cut, or laceration has been inflicted by a person on a limb of a horse;

3. [(c)] A tack, nail, screw, or chemical agent has been injected by a person into or used by a person on a limb of a horse; or

4. [(d)-1.] Any other substance or device has been used by a person on a limb of a horse or a person has engaged in a practice involving a horse; and

[(b) 1. f.] As a result of the application, infliction, injection, use, or practice, the horse suffers, or can reasonably be expected to suffer, physical pain or distress, inflammation, or lameness if walking, trotting, or otherwise moving; and

2. Shall not include an application, infliction, injection, use, or practice in connection with the therapeutic treatment of a horse by or under the supervision of a person licensed to practice veterinary medicine.

(10) "Veal" means a young bovine harvested at or under 750 pounds, and fed for the purpose of veal meat production.

(11) "Veterinarian-client-patient relationship" is defined by KRS 321.185.

JAMES R. COMER, Commissioner

APPROVED BY AGENCY: August 15, 2013

FILED WITH LRC: August 15, 2013 at noon

CONTACT PERSON: Clint Quarles, Staff Attorney, Kentucky Department of Agriculture, 500 Mero Street, 7th Floor, Frankfort Kentucky 40601, phone (502) 564-1155, fax (502) 564-2133.

GENERAL GOVERNMENT CABINET
Department of Agriculture
Office of Consumer and Environmental Protection
Division of Environmental Services
(As Amended at ARRS, December 10, 2013)

Compiler's Note: This administrative regulation was amended at the December 2013 ARRS meeting, and then was deferred as amended for review at the January 2014 ARRS meeting. It is being published in this month's Register following completion of the ARRS review.

302 KAR 21:060. Swine Specific Provisions.

RELATES TO: KRS 257.196, 525.130

STATUTORY AUTHORITY: KRS 257.196

NECESSITY, FUNCTION, AND CONFORMITY: KRS 257.196 requires the Board of Agriculture to promulgate administrative regulations establishing on-farm livestock and poultry care standards recommended to it by the Kentucky Livestock Care Standards Commission. This administrative regulation establishes additional livestock standards and specifically authorized practices for swine.

Section 1. The provisions of 302 KAR 21:020 apply to on-farm livestock and poultry in Kentucky, except as provided by this administrative regulation. This administrative regulation adds additional standards and specifically authorized practices to 302 KAR 21:020 for swine.

Section 2. (1) Additional Standards.

(a) If being transported, swine shall be able to stand in their natural position without touching the top of the transport conveyance.

(b) Body condition may be evaluated using the Pork Quality Assurance Guidelines.

(2) Authorized Practices. The following shall be authorized practices:

(a) Castration;

(b) Needle teeth clipping;

(c) Boar tusk removal;

(d) Tail docking;

(e) Identification using ear notching, tattooing, or ear tagging;

(f) Environmentally controlled housing. Swine may be raised in environmentally controlled housing designed in a manner that minimizes the effects of adverse weather conditions;

(g) Stalls, pens, or outdoor lots with shelters if used for gestating sows; and

(h) Crates, pens, or outdoor huts if used for farrowing and lactating sows.

Section 3. Incorporation by Reference. (1) "Pork Quality Assurance Guidelines". 2013. is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Agriculture, 100 Fair Oaks, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

JAMES R. COMER, Commissioner

APPROVED BY AGENCY: August 15, 2013

FILED WITH LRC: August 15, 2013 at noon

CONTACT PERSON: Clint Quarles, Staff Attorney, Kentucky Department of Agriculture, 500 Mero Street, 7th Floor, Frankfort, Kentucky 40601, phone (502) 564-1155, fax (502) 564-2133.

GENERAL GOVERNMENT CABINET
Department of Agriculture
Office of Agricultural Marketing and Product Promotion

302 KAR 40:010. Certification of organic production, processing, or handling operations.

RELATES TO: KRS 260.020, 260.030, 260.038, 7 C.F.R. 205
STATUTORY AUTHORITY: KRS 260.020(3), 260.030(1)(k), 7 C.F.R. 205

NECESSITY, FUNCTION, AND CONFORMITY: KRS 260.020(3) authorizes the commissioner of the Kentucky Department of Agriculture to promulgate administrative regulations to carry out any programs established under the Office for Agricultural Marketing and Product Promotion and to establish fees for the administration of those programs. KRS 260.030(1)(k) requires the Office for Agricultural Marketing and Product Promotion~~Department of Agriculture~~ to establish an Organic Agricultural Product Certification Program. This administrative regulation establishes the procedures for certification of organically-produced agricultural products~~foods~~.

Section 1. ~~A producer, processor, or handler~~~~[All producers, processors, and handlers]~~ of organic agricultural products shall comply with:

~~(a) 7 C.F.R. Part 205, the National Organic Program;~~

~~(b) The KDA Organic Certification Program Quality Manual; and~~

~~(c) The standards contained in the certification application required by Section 2(1) of this administrative regulation.~~

~~(2) The department shall administer the Organic Certification Program in accordance with the KDA Organic Certification Program Quality Manual~~~~[the requirements of 7 C.F.R. 205].~~

Section 2. Certification. (1) To receive or maintain organic certification, a completed application form shall be submitted to the department annually.

(a) A producer shall submit an Organic Farm Certification Application.

(b) A processor or handler shall submit:

1. An Organic Processing/Handling Certification Application; and

2. An Organic Product Profile for each product to be certified.

(c) A producer requesting certification of livestock shall also submit an Organic Livestock Certification Application.

(d) Relevant supporting documentation required by an application shall be submitted with the application~~[A producer, processor, or handler seeking to receive or maintain organic certification shall submit a completed application including all relevant supporting documents required under this administrative regulation]~~~~[the organic certification program fee schedule, organic product profile, and organic certification withdrawal notification].~~

(2) The production, processing, or handling operation shall be inspected by the department.

(a) The inspector shall be trained as required by the KDA Organic Certification Program Quality Manual.

(b) The applicant shall be present during the inspection.

(c) The inspector shall complete the appropriate field inspection report:

1. The KDA Organic Crop Inspection Report;

2. The KDA Organic Livestock Inspection Report; or

3. The Processing/Handler Organic Inspection Report.

(d) An exit interview shall be conducted using the Organic Inspection Exit Interview form.

(e) [A trained] [certified] [inspector shall complete a field inspection report of the organic production entity, and the applicant shall be present during the inspection.] Upon receipt of a field inspection report, the department shall make a determination of certification and notify the applicant in writing of its decision. If the written application and the field inspection report demonstrate compliance with this administrative regulation and 7 C.F.R. 205, the department shall grant certification.

(3) The department shall conduct an annual inspection of every certified organic entity.

(4) Except as provided by subsection (5)[6] of this section and Section 3 of this administrative regulation, a producer, processor, or handler shall pay a certification fee of \$250[\$125] for the initial certification scope and each year thereafter when renewed. Subsequent scopes beyond the initial shall be charged at \$125 and each year thereafter when renewed. Except as provided by subsection (5)[6] of this section and Section 3 of this administrative regulation, processors and handlers shall pay an additional fee of \$100 per each \$100,000 increment of gross receipts that exceed \$100,000. Fees shall be calculated in accordance with the Organic Program Fee Schedule~~[a certification fee of \$125 plus \$100 for each \$100,000 of gross receipts for each organic product].~~

(5) [Any] production, processing, or handling operation with gross agricultural income from organic sales of less than \$5,000 annually shall register with the department by using the Exempt Organic Operation Registration form. There shall not be a fee to register.

(6) To withdraw a certification application, a Withdrawal of USDA National Organic Program Certification Application form shall be submitted to the department. The withdrawal procedures listed on the form shall be followed.

(7) To voluntarily surrender an organic certification, a Voluntary Surrender of USDA National Organic Program Certification form shall be submitted to the department. The surrendering procedures listed on the form shall be followed.

(5) Nonresident organic producers, processors, and handlers may be certified in Kentucky if they meet the following requirements:

(a) The organic products are sold, processed, or handled in Kentucky;

(b) The producers, processors, or handlers' state of residence does not have an organic certification program; and

(c) The producers shall pay a certification fee of \$250. Processors and handlers shall pay a certification fee of \$250 plus \$100 for each \$100,000 of gross receipts for each organic product. In addition to the certification fee established for nonresident producers, processors, and handlers, the department shall be reimbursed for all expenses incurred as a result of the certification procedure.

(6) Any production, processing, or handling operation with gross agricultural income from organic sales of less than \$5,000 annually shall register with the department and pay an annual fee of twenty-five (25) dollars].

Section 3. Nonprofit, Educational, or[and] Charitable Organization. (1) If a nonprofit, educational, or[and] charitable organization[organizations], as defined by the Internal Revenue Code, 26 U.S.C. 501(c)(3), has[have] at least \$5,000 gross sales of organic products, it[they] shall be certified and pay the required fees in accordance with Section 2 of this administrative regulation.

(2) If a nonprofit, educational, or[and] charitable organization[organizations], as defined by the Internal Revenue Code, 26 U.S.C. 501(c)(3), has[have] less than \$5,000 gross sales of organic products, it[they] shall be registered for production, processing, or handling organic products by using the Exempt Organic Operation Registration form. There shall not be a fee to register~~[except they shall not be required to pay a fee].~~

Section 4. ~~[Nonresident Certifiers. (1) Kentucky producers, processors, and handlers of organic products may be certified by nonresident certifiers if the certifiers are registered with the Kentucky Department of Agriculture. Registration shall require the following:~~

~~(a) Name of the certifier;~~

~~(b) Address of certifier;~~

~~(c) Name and address of the entity to be certified; and~~

~~(d) Documentation that the certifier is certified pursuant to National Organic Program requirements, 7 U.S.C. 6501-6522 and 7 C.F.R. 205.~~

~~(2) Nonresident certifiers shall not initiate the certification process until they have registered and submitted all required information.~~

Section 5. The department shall devise and distribute a label in conformance with 7 C.F.R. 205.303. Producers, processors, and handlers shall be certified by the department prior to using the label. The cost of the label shall be included in the certification fee. Certified producers, processors, and handlers shall be provided a roll of 400 labels or an ink slick that may be reproduced.

Section 6. ~~Organic Agriculture~~~~[Certification Review and Standards]~~ Advisory Committee. (1) The ~~Organic Agriculture~~~~[Certification Review and Standards]~~ Advisory Committee shall consist of seven (7) members. At least three (3) of the members shall be farmers who produce organic products. The other four (4) members may include, including consumers, advocates, handlers, or processors of organic products~~[and at least three (3) farmers who produce organic products].~~

(2) The committee shall be appointed by the commissioner and serve a term of two (2) years. Members may be reappointed to additional two (2) year terms.

(3) The committee shall ~~develop~~[determine policy regarding organic production, processing, and handling] recommendations to promote and expand the organic agricultural products industry in Kentucky.

(4) Members shall receive reimbursement for mileage only for meetings of the full committee.

Section 5. Exports. *If export documentation is requested, the procedures established in the KDA Organic Certification Program Quality Manual shall be followed. The applicant shall pay an additional fee of fifty (50) dollars in accordance with the Organic Program Fee Schedule.*~~The KDA shall additionally charge a fifty (50) dollar fee for each entity the National Organics Program has an established trade agreement with, for the preparation of documents~~[Section 7. Federal Regulations Adopted Without Change. The following federal regulations govern the subject matter of this administrative regulation and are hereby adopted without change. The federal regulations are available for inspection and copying, during normal business hours of 8 a.m. to 4:30 p.m., eastern time, excluding state holidays, at the Office of Agricultural Marketing and Product Promotion, 100 Fair Oaks, Frankfort, Kentucky, or may be purchased from the U.S. Superintendent of Documents, Washington, D.C.: 7 C.F.R. 205, "National Organic Program, January 1, 2001"].

Section 6.[8.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Organic Farm Certification Application", December [October] 2013[Organic Farm/Crop Certification Application (June 2003)];

(b) "Organic Processing/Handling Certification [Process/Handling Plan] Application", December [October] 2013[(July 2003)];

(c) "Organic Livestock Certification Application", December [October] 2013[Organic Livestock Plan Application (July 2003)];

(d) "Organic Certification Program Fee Schedule", October 2013[(November 2003)];

(e) "Organic Product Profile", December [October] 2013[(November 2003)]; [and]

(f) "Withdrawal of USDA National Organic Program Certification Application", October 2013;

(g) "Voluntary Surrender of USDA National Organic Program Certification", October 2013; [and]

(h) "KDA Organic Certification Program Quality Manual", December [October] 2013;

(i) "Exempt Organic Operation Registration", December 2013;

(j) "Organic Inspection Exit Interview", May 2002;

(k) "KDA Organic Crop Inspection Report", December 2013;

(l) "KDA Organic Livestock Inspection Report", December 2013; and

(m) "Processing/Handler Organic Inspection Report", December 2013[Organic Certification Withdrawal Notification" (November 2003)].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Agriculture, Office of Agricultural Marketing and Product Promotion, 100 Fair Oaks, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. The material is also available on the department Web site at www.kyagr.com.

JAMES R. COMER, Commissioner

APPROVED BY AGENCY: October 15, 2013

FILED WITH LRC: October 15, 2013 at noon

CONTACT PERSON: Clint Quarles, Staff Attorney, Kentucky Department of Agriculture, 500 Mero Street, 7th Floor, Frankfort Kentucky 40601, phone (502) 564-1155, fax (502) 564-2133.

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Kentucky Board of Education
Department of Education
(As Amended at ARRS, January 13, 2014)

702 KAR 7:125. Pupil attendance.

RELATES TO: KRS 157.320, 157.350, 157.360, 158.030, 158.070, 158.100, 158.240, 159.010, 159.030, 159.035, 159.140, 159.170, 161.200

STATUTORY AUTHORITY: KRS 156.070, 156.160, 157.320, 158.070

NECESSITY, FUNCTION, AND CONFORMITY: KRS 157.320 defines average daily attendance of pupils for funding purposes under the Support Education Excellence in Kentucky (SEEK) Program. KRS 157.360 bases SEEK funding upon average daily attendance. KRS 158.030, 158.100, and 159.010[159.030] establish the age for compulsory school attendance. KRS 158.070 defines the school term. KRS 158.240 and 159.035 define attendance credit for moral instruction and 4-H activities. KRS 161.200 requires attendance records to be kept by teachers. This administrative regulation establishes a uniform method of recording pupil attendance.

Section 1. Daily attendance. (1) Daily attendance of pupils in elementary schools shall be determined by taking attendance one (1) time each day prior to the start of instruction and maintaining a pupil[student] entry and exit log at each school.

(2) Daily attendance of pupils in middle and high schools[school] shall be determined by taking attendance by class period and maintaining a pupil[student] entry and exit log at each school.

(3) The pupil[student] entry and exit log shall include the date, pupil[student] name, grade or homeroom, time of late arrival, time of early departure (with the reason for both listed), and other information required by the local board of education. For elementary pupils[students] who are signed out, the pupil[student] entry and exit log shall also include a signature of:

(a) A parent;

(b) A legal guardian; or

(c) An adult with proof of identification and for whom the school has received a written authorization from the parent or legal guardian.

(4) Pupils shall be physically present in the school to be counted in attendance except under the following conditions:

(a) The pupil is a participant in a co-curricular instructional activity that has been authorized by the local board of education and is a definite part of the instructional program of the school;

(b) The pupil is a participant in an activity as provided in either KRS 158.240 or 159.035;

(c) The pupil is participating in an off-site virtual high school class or block. A pupil[student] may be counted in attendance for a virtual high school class or block for the year or semester in which the pupil[student] initially enrolled in the class or block if the pupil[student] demonstrates proficiency in accordance with local policies required by 704 KAR 3:305, Section 5(2)(b) or (3);

(d) The pupil's mental or physical condition prevents or renders inadvisable attendance in a school setting, and the pupil meets the requirements of KRS 159.030(2). A pupil being served in the home/hospital program shall receive a minimum of one (1) hour of instruction two (2) times per five (5) instructional days;

(e) The pupil [student] has been court ordered to receive educational services in a setting other than the classroom. A pupil being served through a court order shall receive a minimum of one (1) hour of instruction two (2) times per five (5) instructional days;

(f) The pupil[student] has an individual education plan (IEP) that requires less than full-time instructional services;

(g) The pupil is participating in standards-based, performance-based credit that is awarded in accordance with 704 KAR 3:305, Section 5(2)(b) and that falls within one (1) or more of the categories of standards-based course work outlined in 704 KAR 3:305, Section 2. A pupil[student] may be counted in attendance for performance-based credit for a class or block for the year or

semester in which the pupil[student] initially enrolled in the class or block if the pupil[student] demonstrates proficiency in accordance with local policies required by 704 KAR 3:305, Section 5(3); or

(h) The pupil participates in a school that is authorized by the commissioner[~~of Education~~] to design and deliver an educational program so that all graduation requirements are based on pupil[student] proficiency of standards and performance, rather than time and Carnegie units, as authorized in 704 KAR 3:305, Section 5.

(5) Even if a pupil's absence or tardy is due to factors beyond the pupil's control, including inclement weather or failure of the transportation system to operate, the pupil shall be counted absent or tardy.

(6) The local board of education shall determine by local board policy what constitutes an excused and an unexcused absence.

(7) A pupil shall not be allowed to make up absences for the purpose of including make-up activities in the calculation of average daily attendance.

Section 2. Calculation of attendance.~~[The guidelines in this section shall be used to calculate student attendance for state funding purposes through June 30, 2010.~~

(1) ~~A full day of attendance shall be recorded for a pupil who is in attendance 100 percent of the regularly-scheduled school day for the pupil's grade level.~~

(2) ~~A tardy shall be recorded for a pupil who is absent sixty (60) minutes or less of the regularly-scheduled school day for the pupil's grade level.~~

(3) ~~The actual percentage of the school day shall be recorded for attendance of a pupil absent for more than sixty (60) minutes of the regularly-scheduled school day for the pupil's grade level.~~

(4) ~~A full day absence shall be recorded for a pupil who is absent 100 percent of the regularly-scheduled school day for the pupil's grade level.~~

(5) ~~The percentages described in this section shall apply to the regularly-scheduled school day approved by the local board of education and shall be applicable to entry level through grade level twelve (12). Section 3.] The guidelines in this section shall be used to calculate pupil[student] attendance for state funding purposes[after June 30, 2010].~~

(1) A full day of attendance shall be recorded for a pupil who is in attendance at least sixty-five (65) percent of the regularly-scheduled school day for the pupil's grade level.

(2) A tardy shall be recorded for a pupil who is absent thirty-five (35) percent or less of the regularly-scheduled school day for the pupil's grade level.

(3) A half day absence shall be recorded for a pupil who is absent thirty-six (36) percent to eighty-four (84) percent of the regularly-scheduled school day for the pupil's grade level.

(4) A full day absence shall be recorded for a pupil who is absent more than eighty-four (84) percent of the regularly-scheduled school day for the pupil's grade level.

Section 3. Shortened school day.~~[4.]~~ A local board of education may permit an arrangement whereby a pupil has a shortened school day in accordance with KRS 158.060, or local board of education policy. The time a pupil[student] is in attendance shall be included in calculating the district's average daily attendance.

Section 4. Dual enrollment.~~[5.]~~ A local board of education may permit an arrangement in which a pupil pursues part of the pupil[s][student's] education under the direction and control of one (1) public school and part of the pupil[s][student's] education under the direction and control of another public or nonpublic school. The time a pupil[student] is served by each public school shall be included when calculating the district's average daily attendance.

Section 5. Private school placement.~~[6.]~~ If a local school district, under the provisions of KRS 157.360(7)[157.360(6)], enrolls a child with a disability in a private school or agency, the private school or agency shall certify the attendance of the child to the local school district at the close of each school month.

Section 6. Age of pupil.~~[7.]~~ (1) Prior to the 2017-18 school year, if a local school district enrolls in the entry level program a pupil~~[in the entry level program]~~ who will not be five (5) years of age on or before October 1 of the year of enrollment, the total aggregate days attendance for the pupil shall not be included in calculating the district's average daily attendance. Beginning with the 2017-18 school year, if a local school district enrolls in the entry level program a pupil who will not be five (5) years of age on or before August 1 of the year of enrollment, the total aggregate days attendance for the pupil shall not be included in calculating the district's average daily attendance.

(2) Prior to the 2017-18 school year, if a local school district enrolls in the second level of the primary program a pupil~~[in the second level of the primary program]~~ who will not be six (6) years of age on or before October 1 of the year of enrollment, the total aggregate days attendance for the pupil shall not be included in calculating the district's average daily attendance except under the conditions established in this subsection. Beginning with the 2017-18 school year, if a local school district enrolls in the second level of the primary program a pupil who will not be six (6) years of age on or before August 1 of the year of enrollment, the total aggregate days attendance for the pupil shall not be included in calculating the district's average daily attendance except under the conditions established in this subsection.

(a) The local board of education shall have determined that the pupil[student] is eligible for enrollment in[into] the second level of the primary program after academic, social, and developmental progress records from multiple data sources are reviewed by a team and determined to support accelerated placement. These sources shall include:

1. Anecdotal records;
2. A variety of pupil[student] work samples, including evidence of pupil[student] self-reflection; and
3. Standardized test results.

(b) The team shall be comprised of three (3) members who have knowledge of the pupil[s][student's] developmental skills and abilities. Team members shall be chosen from these categories:

1. Teachers;
2. Parents;
3. Psychologists;
4. Principals; or
5. District specialists.

(c) At least one (1) team member shall represent the district office and have an understanding of early childhood development and knowledge of developmentally-appropriate practices.

(d) If a pupil[student] is recommended by the local board of education for accelerated placement into the second level of the primary program, the district shall forward that recommendation to the department for approval with:

1. A list of data sources used in making the decision;
2. A list of all individuals who submitted the data sources;
3. A list of team members; and
4. The data needed to create a pupil attendance record.

(3) A local school district shall enroll any resident pupil, not holding a high school diploma, under the age of twenty-one (21) years ~~[of age]~~ who wishes to enroll. The days attended after the pupil's twenty-first (21st)[student's 21st] birthday shall not be included in the calculation of the district's average daily attendance.

Section 7. Due Dates for Certain Reports. (1)~~[8.]~~ The Growth Factor Report for the first two (2) school months of the school year created pursuant to KRS 157.360(9)[157.360(8)] shall be submitted to the department~~[of Education]~~ within ten (10) business days following the last day of the second school month or by November 1 of each year, whichever occurs first.

(2) Pursuant to KRS 157.360(2), the Superintendents Annual Attendance Report (SAAR) for the school year shall be submitted to the department by June 30 of each year.

Section 8. Nonresident pupils.~~[9.]~~ (1)(a) A written agreement executed by local boards of education~~[execute]~~ for enrollment of nonresident pupils as provided by KRS 157.350(4)~~(a)~~ shall be filed

in both the attending district and the resident district no later than February 1 of the year prior to the school year to which it will apply.

(b) The written agreement shall include the specific terms to which the districts have agreed.

(c) A list of the names of all nonresident pupils enrolled in the attending district covered by the agreement shall be filed in both the attending district and the resident district not later than November 1 of the school year covered by the agreement.

(d)[(2)] A change may be made to the original nonresident pupil agreement up to the close of the school year to include the nonresident pupils enrolling after the close of the second school month. The amendment shall be filed in both the attending district and the resident district no later than June 30 of each year.

(2) A list of the names of all nonresident pupils whose parent is an employee of the district as provided by KRS 157.350(4)(b) and who are not covered by the nonresident agreement shall be filed in both the attending district and the resident district not later than November 1 of the school year.

Section 9. Weather-related low attendance days. (1)[40.] The [Superintendent's Annual Attendance Report (SAAR)] shall be considered:

(a) The request to substitute prior year's average daily attendance for up to ten (10) designated weather-related low attendance days; and

(b) Certification that the low attendance was due to inclement weather, in accordance with KRS 157.320(17).

(2) Documentation that the low attendance was due to inclement weather shall be retained at the central office.

Section 10. Health and safety closings. (1) The SAAR shall be considered:

(a) The request to substitute prior year's average daily attendance for up to ten (10) designated instructional days, in accordance with KRS 158.070(10); [for school districts that have missed an average of twenty (20) or more days in the previous three (3) years on days a school district is closed for health and safety reasons.] and

(b) Certification that the low attendance was due to health and safety reasons [in accordance with KRS 158.070(10)].

(2) Documentation that the low attendance was due to health and safety reasons shall be retained at the central office.

(3) Days granted in this section shall be in addition to any days granted under Section 9 of this administrative regulation.

Section 11. Original source of attendance data. (1) The school's records of daily attendance and teacher's monthly attendance reports, daily and class period absentee lists, pupil[student] entry and exit logs, and the Home/Hospital Program Form, shall be the original source of attendance data for all pupils enrolled in the public common schools and shall be verified at the end of each school month.

(2) The school's records of daily attendance and teachers' monthly attendance reports shall be signed by a designated certified person within the elementary or secondary school who shall be responsible for verifying and certifying the state attendance documents for accuracy.

(3) The school's records of daily attendance and tenth month teacher's monthly attendance reports shall be retained at least twenty (20) years. The daily and class period absentee lists, and pupil[student] entry and exit logs shall be retained at least two (2) full school years after the current school year.

Section 12. Enrollment codes. The following entry, reentry, and withdrawal codes shall be used to indicate the enrollment status of pupils:

(1) E01 - A pupil enrolled for the first time during the current year in either a public or nonpublic school in the United States;

(2) E02 - A pupil previously enrolled during the current school year in either a public or nonpublic school in another state who has not previously enrolled in Kentucky during the current school year;

(3) E03 - A pupil enrolling for the first time during the current school year in either a public or nonpublic school, who withdrew as

a W06, W07, W13, W16, or W18 during the 2004-2005 school year or as a W24 or W25 for previous school years;

(4) R01 - A pupil received from another grade or grade level in the same school year, or having a change in schedule structure or enrollment service type;

(5) R02 - A pupil received from another public school in the same public school district;

(6) R06 - A pupil reentering the school after dropping out, discharge, or expulsion from a school district in Kentucky during the current school year, who has not entered any other school during the intervening period;

(7) R20 - A pupil previously enrolled in a home school in Kentucky during the current school year;

(8) R21 - A pupil previously enrolled in any public or nonpublic school (excluding home schools) in Kentucky during the current school year;

(9) W01 - A pupil transferred to another grade in the same school or with grade level changes in the same school mid-year, or with a change in schedule structure or enrollment service type. The reentry code to use with W01 shall be R01;

(10) W02 - A pupil transferred to another public school in the same public school district. The reentry code to use with W02 shall be R02;

(11) W07 - A pupil withdrawn due to those communicable medical conditions that pose a threat in school environments listed in 902 KAR 2:020, Section 2(1)[4(4)], accompanied by a doctor's statement certifying the condition, or any other health-related condition for which the pupil[student] is too ill to participate in regular school attendance or local homebound instructional services, or if the pupil[student] has obtained a doctor's statement certifying the condition. The reentry code to use with W07 shall be R06;

(12) W08 - A pupil withdrawn due to death;

(13) W12 - A pupil under the jurisdiction of the court. For purposes of the W12 code, a pupil may be considered under the jurisdiction of the court on the day the petition is filed with the court. The reentry code to use with W12 shall be R06. For accountability purposes, a W12 shall be considered a dropout if the district cannot substantiate enrollment in the proper educational setting as designated by the court;

(14) W17 - An entry level pupil[student] in the primary program, withdrawn during the first two (2) months enrolled due to immaturity or mutual agreement by the parent, guardian or other custodian and the school in accordance with 704 KAR 5:060;

(15) W20 - A pupil transferred to a home school. The reentry code to use with W20 shall be R20;

(16) W21 - A pupil transferred to a nonpublic school (excluding home school). The reentry code to use with W21 shall be R21;

(17) W22 - A pupil who has transferred to another Kentucky public school district and for whom a request for pupil[student] records has been received or enrollment has been substantiated; or a pupil who is known to have moved out of the United States];

(18) W23 - A pupil withdrawn for a second or subsequent time who initially withdrew as a W24 or W25 during the current school year;

(19) W24 - A pupil who has moved out of this public school district for whom enrollment elsewhere has not been substantiated;

(20) W25 - Prior to the 2017-18 school year, a pupil who is at least the local board policy's minimum age for withdrawal and has withdrawn from public school; beginning with the 2017-18 school year, a pupil who is at least eighteen (18)[sixteen (16)] years of age and has withdrawn from [dropped out of] public school;

(21) W26 - A pupil who has withdrawn from school after completing a secondary GED program and receiving a GED certificate;

(22) W27 - A pupil who has withdrawn from school and subsequently received a GED;

(23) W28 - A pupil who has reached the maximum age for education services without receiving a diploma or an alternative high school diploma [certificate of attainment];

(24) W29 - A pupil who has moved out of state or out of the United States;

(25) W30 - A pupil with an IEP enrolled in Grade 14 who has

previously received an alternative high school diploma, re-enrolled, and withdrew in the middle of the reporting school year;

(26) C01 - A pupil who completes the school year in the school of the most current enrollment;

(27)[(25)] G01 - A pupil who graduates in less than four (4) years;

(28)[(26)] G02 - A pupil who graduates in four (4) years;

(29)[(27)] G03 - A pupil who graduates in five (5) or more years;

(30)[(28)] G04 - A pupil who graduates in six (6) or more years; and

(31)[(29)] NS - A pupil who completed the prior year with a C01 and was expected to enroll in the district but did not enroll by October 1 of the current year whose enrollment elsewhere cannot be substantiated.

Section 13. Suspension. (1) For a pupil[student] who has been suspended, a code of S shall be used to indicate the days suspended.

(2) Suspension shall be considered an unexcused absence.

Section 14. Ethnicity. The ethnicity of each pupil[student] shall be designated as either Hispanic/Latino or not Hispanic/Latino. The designation shall be "Hispanic/Latino" if the person is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture of origin regardless of race. The term "Spanish origin" may be used in addition to "Hispanic/Latino".

Section 15. Racial category codes. One (1) or more of the following racial codes shall be used to indicate the racial category of pupils:

(1) White - A person having origins in any of the original peoples of Europe, North Africa, or the Middle East;

(2) Black or African American - A person having origins in any of the black racial groups of Africa;

(3) Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, or Vietnam;

(4) American Indian or Alaskan Native - A person, having origins in any of the original peoples of North America and South America (including Central America),[and] who maintains cultural identification through tribal affiliation or community attachment; and

(5) Native Hawaiian or other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Section 16. Withdrawal and transfer records. (1) The Student Dropout Questionnaire shall be completed during the one (1) hour counseling session mandated in accordance with KRS 159.010.~~[Dropout data shall be reported to the Department of Education on the Nonacademic Report that is submitted to the Department each year.]~~

(2) The request for records and other information involving the withdrawal and transfer of pupils shall be processed by the local superintendent or his or her designee pursuant to KRS 159.170, and shall be maintained in the pupil[s][student's] permanent file.

Section 17. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Home/Hospital Program Form", November 2013[2008-2009];

(b) "Student Dropout Questionnaire", November 2013[December 2000];

(c) "Growth Factor Report", November 2013[November 2009]; and

(d) "Superintendent's Annual Attendance Report (SAAR)", November 2013[November 2009; and

(e) "Nonacademic Report", October 2008].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Education,[Division of Finance,] 15th Floor, Capital Plaza Tower, 500 Mero Street, Frankfort, Kentucky 40601, Monday through

Friday, 8 a.m. to 4:30 p.m.

This is to certify that the chief state school officer has reviewed and recommended this administrative regulation prior to its adoption by the Kentucky Board of Education, as required by KRS 156.070(5).

TERRY HOLLIDAY, Ph.D.

ROGER MARCUM, Chairperson

APPROVED BY AGENCY: November 15, 2013

FILED WITH LRC: November 15, 2013 at noon

CONTACT PERSON: Kevin C. Brown, Associate Commissioner and General Counsel, Kentucky Department of Education, 500 Mero Street, First Floor, Capital Plaza Tower, Frankfort, Kentucky 40601, phone 502-564-4474, fax 502-564-9321.

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Community Based Services

Division of Family Support

(As Amended at ARRS, January 13, 2014)

921 KAR 2:015. Supplemental programs for persons who are aged, blind, or have a disability.

RELATES TO: KRS Chapter 194A, 202A.011(12), 209.020(4), 216.530, 216.557(1), 216.750(2), 216.765(2), [216B.010-216B.131,] Chapter 216B, 514, 20 C.F.R. 416.120, 416.212, 416.2030, 416.2095, 416.2096, 416.2099, 8 U.S.C. 1621, 1641, 42 U.S.C. 1381-1383

STATUTORY AUTHORITY: KRS 194A.050(1), 205.245, 42 U.S.C. 1382e-g

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the secretary to promulgate administrative regulations necessary under applicable state laws to protect, develop, and maintain the welfare, personal dignity, integrity, and sufficiency of the citizens of the Commonwealth and to operate the programs and fulfill the responsibilities of the cabinet. 42 U.S.C. 1382 authorizes the cabinet to administer a state funded program of supplementation to all former recipients of the Aid to the Aged, Blind, and Disabled Program as of December 13, 1973, and who were disadvantaged by the implementation of the Supplemental Security Income Program. KRS 205.245 establishes the mandatory supplementation program and the supplementation to other needy persons who are aged, blind, or have a disability. In addition, any state that makes supplementary payments on or after June 30, 1977, and does not have a pass-along agreement in effect with the Commissioner of the Social Security Administration, formerly a part of the U.S. Department of Health, Education, and Welfare, shall be determined by the commissioner to be ineligible for payments under Title XIX of the Social Security Act in accordance with 20 C.F.R. 416.2099. This administrative regulation establishes the provisions of the supplementation program.

Section 1. Definitions. (1) "Adult" is defined by KRS 209.020(4).

(2) "Aid to the Aged, Blind and Disabled Program" means the former state-funded program for an individual who was aged, blind, or had a disability.

(3) "Care coordinator" means an individual designated by a community integration supplementation applicant or recipient to fulfill responsibilities specified in Section 6(2) of this administrative regulation.

(4) "Department" means the Department for Community Based Services or its designee.

(5)[(4)] "Full-time living arrangement" means a residential living status that is seven (7) days a week, not part time.

(6) "Private residence" means a dwelling that meets requirements of Section 4(2)(d) of this administrative regulation.

(7)[(5)] "Qualified alien" means an alien who, at the time the person applies for, receives, or attempts to receive state supplementation, meets the U.S. citizenship requirements of 907

KAR 20:001[1:011].

(8) "Qualified mental health professional" is defined by KRS 202A.011(12).

(9) "Serious mental illness" or "SMI" means a mental illness or disorder in accordance with Section 6(1) of this administrative regulation.

(10)[(6)] "Specialized personal care home" means a licensed personal care home that receives funding from the Department for Behavioral Health, Developmental and Intellectual Disabilities to employ a mental health professional who has specialized training in the care of a resident with mental illness or mental retardation.

(11)[(7)] "Supplemental security income" or "SSI" means a monthly cash payment made pursuant to 42 U.S.C. 1381 to 1383f to the aged, blind, or disabled.

Section 2. Mandatory State Supplementation. (1) A recipient for mandatory state supplementation shall include a former Aid to the Aged, Blind and Disabled Program recipient who became ineligible for SSI due to income but whose special needs entitled the recipient to an Aid to the Aged, Blind and Disabled Program payment as of December 1973.

(2) A mandatory state supplementation recipient shall be subject to the same payment requirements as specified in Section 4 of this administrative regulation.

(3) A mandatory state supplementation payment shall be equal to the difference between:

(a) The Aid to the Aged, Blind and Disabled Program payment for the month of December 1973; and

(b)1. The total of the SSI payment; or

2. The total of the SSI payment and other income for the current month.

(4) A mandatory payment shall discontinue if:

(a) The needs of the recipient as recognized in December 1973 have decreased; or

(b) Income has increased to the December 1973 level.

(5) The mandatory payment shall not be increased unless:

(a) Income as recognized in December 1973 decreases;

(b) The SSI payment is reduced, but the recipient's circumstances are unchanged; or

(c) The standard of need as specified in Section 9[8] of this administrative regulation for a class of recipients is increased.

(6) If a husband and wife are living together, an income change after September 1974 shall not result in an increased mandatory payment unless total income of the couple is less than December 1973 total income.

Section 3. Optional State Supplementation Program. (1) Except as established in Sections 7, 8, and 9[6, 7, and 8] of this administrative regulation, optional state supplementation shall be available to a person who meets technical requirements and resource limitations of the medically needy program for a person who is aged, blind, or has a disability in accordance with:

(a) 907 KAR 20:001;

(b) 907 KAR 20:005, Sections 5(2), (3), (4), (7), 10, and 11;

(c) 907 KAR 20:020, Section 2(4)(a);

(d) 907 KAR 20:025; and

(e) 907 KAR 20:040, Section 1[907 KAR 1:011, Sections 1(7), (8), 5(5), (6), (7), (13), 10, and 11;

(b) 907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);

(c) 907 KAR 1:645;

(d) 907 KAR 1:650, Section 1(9); and

(e) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4)].

(2) A person shall apply or reapply for the state supplementation program in accordance with 921 KAR 2:035 and shall be required to:

(a) Furnish a Social Security number; or

(b) Apply for a Social Security number, if a Social Security number has not been issued.

(3) If potential eligibility exists for SSI, an application for SSI shall be mandatory.

(4) The effective date for state supplementation program approval shall be in accordance with 921 KAR 2:050.

Section 4. Optional State Supplementation Payment. (1) An optional supplementation payment shall be issued in accordance with 921 KAR 2:050 for an eligible individual who:

(a) Requires a full-time living arrangement;

(b) Has insufficient income to meet the payment standards specified in Section 9[8] of this administrative regulation; and

(c)1. Resides in a personal care home and is eighteen (18) years of age or older in accordance with KRS 216.765(2);

2. Resides in a family care home and is at least eighteen (18) years of age in accordance with 902 KAR 20:041, Section 3(14);[or]

3. Receives caretaker services and is at least eighteen (18) years of age; or

4. a. Resides in a private residence;

b. Is at least eighteen (18) years of age; and

c. Has SMI.

(2) A full-time living arrangement shall include:

(a) Residence in a personal care home that:

1. Meets the requirements and provides services established in 902 KAR 20:036; and

2. Is licensed under KRS 216B.010 to 216B.131;

(b) Residence in a family care home that:

1. Meets the requirements and provides services established in 902 KAR 20:041; and

2. Is licensed under KRS 216B.010 to 216B.131;[or]

(c) A situation in which a caretaker is required to be hired to provide care other than room and board; or

(d) A private residence, which shall:

1. Be permanent housing with:

a. Tenancy rights; and

b. Preference given to single occupancy; and

2. Afford an individual with SMI choice in activities of daily living, social interaction, and access to the community.

(3) A guardian or other payee who receives a state supplementation check for a state supplementation recipient shall:

(a) Return the check to the Kentucky State Treasurer, the month after the month of:

1. Discharge to a:

a. Nursing facility, unless the admission is for temporary medical care as specified in Section 10[9] of this administrative regulation; or

b. Residence other than a private residence pursuant to subsection (2)(d) of this section; or

2. Death of the state supplementation recipient; and

(b) Notify a local county department office within five (5) working days of the death or discharge of the state supplementation recipient.

(4) Failure to comply with subsection (3)(a) of this section may result in prosecution in accordance with KRS Chapter 514.

(5) If there is no guardian or other payee, a personal care or family care home that receives a state supplementation check for a state supplementation recipient shall:

(a) Return the check to the Kentucky State Treasurer, the month after the month of:

1. Discharge to a:

a. Nursing facility, unless the admission is for temporary medical care as specified in Section 10[9] of this administrative regulation;

b. Another personal care or family care home; or

c. Residence other than a private residence pursuant to subsection (2)(d) of this section; or

2. Death of the state supplementation recipient; and

(b) Notify a local county department within five (5) working days of the:

1. Death or discharge of the state supplementation recipient; or

2. Voluntary relinquishment of a license to the Office of Inspector General.

(6) If a personal care or family care home receives a state supplementation check after voluntary relinquishment of a license, as specified in subsection (5)(b)2 of this section, the personal care or family care home shall return the check to the Kentucky State Treasurer.

(7) Failure to comply with subsections (5)(a) or (6) of this

section may result in prosecution in accordance with KRS Chapter 514.

Section 5. Eligibility for Caretaker Services. (1) Service by a caretaker shall be provided to enable an adult to:

- (a) Remain safely and adequately:
 1. At home;
 2. In another family setting; or
 3. In a room and board situation; and
- (b) Prevent institutionalization.

(2) Service by a caretaker shall be provided at regular intervals by:

- (a) A live-in attendant; or
- (b) One (1) or more persons hired to come to the home.
- (3) Eligibility for caretaker supplementation shall be verified annually by the cabinet with the caretaker to establish how:

- (a) Often the service is provided;
- (b) The service prevents institutionalization; and
- (c) Payment is made for the service.

(4) A supplemental payment shall not be made to or on behalf of an otherwise eligible individual if the:

- (a) Client is taken daily or periodically to the home of the caretaker; or
- (b) Caretaker service is provided by the following persons living with the applicant:
 1. The spouse;
 2. Parent of an adult or minor child who has a disability; or
 3. Adult child of a parent who is aged, blind, or has a disability.

Section 6. Eligibility for Community Integration Supplementation. (1) Eligibility for the community integration supplementation shall be based upon a diagnosis of SMI by a qualified mental health professional. SMI shall:

(a) Not include a primary diagnosis of Alzheimer's disease or dementia;

(b) Be described in the Diagnostic and Statistical Manual of Mental Disorders (DSM), fourth (4th) edition or edition currently in use;

(c) Impair or impede the individual's functioning in at least one (1) major area of living such as inability to care for or support self, communicate, or make and maintain interpersonal relationships; and

(d) Be unlikely to improve without treatment, services, or supports.

(2) Eligibility for the community integration supplementation shall be verified annually by the cabinet with the applicant or recipient's care coordinator to establish how:

- (a) Often services are provided;
- (b) The services prevent institutionalization and support private residence in accordance with Section 4(2)(d) of this administrative regulation; and
- (c) Payment is made for the services.

(3) Unless criteria in Section 10 of this administrative regulation are met by the applicant or recipient, SMI supplementation shall not be available to a resident of a home, facility, institution, lodging, or other establishment:

- (a) Licensed or registered in accordance with KRS Chapter 216B; or
- (b) Certified in accordance with KRS Chapter 194A.

Section 7. Resource Consideration. (1) Except as stated in subsection (2) of this section, countable resources shall be determined according to policies for the medically needy in accordance with:

- (a) 907 KAR 20:001;
- (b) 907 KAR 20:020, Section 2(4)(a);
- (c) 907 KAR 20:025; and
- (d) 907 KAR 20:040, Section 1[907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);
- (b) 907 KAR 1:645;
- (c) 907 KAR 1:650, Section 1(9); and
- (d) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4)].
- (2) An individual or couple shall not be eligible if countable

resources exceed the limit of:

- (a) \$2000 for an individual; or
- (b) \$3000 for a couple.

Section 8.[7.] Income Considerations. (1) Except as noted in subsections (2) through (8) of this section, income and earned income deductions shall be considered according to the policy for the medically needy in accordance with:

- (a) 907 KAR 20:001;
- (b) 907 KAR 20:020, Section 2(4)(a);
- (c) 907 KAR 20:025; and
- (d) 907 KAR 20:040, Section 1[907 KAR 1:640, Sections 1(1), (6), (7), (11), 3(4)(a);
- (b) 907 KAR 1:645;
- (c) 907 KAR 1:650, Section 1(9); and
- (d) 907 KAR 1:660, Sections 1(1), (5), 2(1), (2), (3), and (4)].

(2) The optional supplementation payment shall be determined by:

- (a) Adding:
 1. Total countable income of the applicant or recipient, or applicant or recipient and spouse; and
 2. A payment made to a third party on behalf of an applicant or recipient; and

(b) Subtracting the total of paragraph (a)1 and 2 of this subsection from the standard of need in Section 9[8] of this administrative regulation.

(3) Income of an ineligible spouse shall be:

- (a) Adjusted by deducting sixty-five (65) dollars and one-half (1/2) of the remainder from the monthly earnings; and
- (b) Conserved in the amount of one-half (1/2) of the SSI standard for an individual for:

1. The applicant or recipient; and
2. Each minor dependent child.

(4) Income of an eligible individual shall not be conserved for the needs of the ineligible spouse or minor dependent child.

(5) Income of a child shall be considered if conserving for the needs of the minor dependent child so the amount conserved does not exceed the allowable amount.

(6) The earnings of the eligible individual and ineligible spouse shall be combined prior to the application of the earnings disregard of sixty-five (65) dollars and one-half (1/2) of the remainder.

(7) If treating a husband and wife who reside in the same personal care or family care home as living apart prevents them from receiving state supplementation, the husband and wife may be considered to be living with each other.

(8) The SSI twenty (20) dollar[dollars] general exclusion shall not be an allowable deduction from income.

Section 9.[8.] Standard of Need. (1) To the extent funds are available, the standard of need is as follows:

- (a) For a resident of a personal care home on or after:
 1. January 1, 2013, \$1,230; or
 2. January 1, 2014, \$1,241;

- (b) For a resident of a family care home on or after:
 1. January 1, 2013, \$882; or
 2. January 1, 2014, \$893;

(c) For individuals who receive caretaker services:

1. A single individual, or an eligible individual with an ineligible spouse who is not aged, blind, or has a disability on or after:

- a. January 1, 2013, \$772; or
- b. January 1, 2014, \$783;

2. An eligible couple, both aged, blind, or have a disability and one (1) requiring care on or after:

- a. January 1, 2013, \$1,127; or
- b. January 1, 2014, \$1,143; or

3. An eligible couple, both aged, blind or have a disability and both requiring care on or after:

- a. January 1, 2013, \$1,181; or
- b. January 1, 2014, \$1,197; or

(d) For an individual who resides in a private residence and has SMI on or after:

1. November 14[1], 2013, \$1,230; or
2. January 1, 2014, \$1,241.

(2)(a) In a couple case, if both are eligible, the couple's income shall be combined prior to comparison with the standard of need.

(b) One-half (1/2) of the deficit shall be payable to each.

(3) A personal care home shall accept as full payment for cost of care the amount of the standard, based on the living arrangement, minus a sixty (60) ~~dollar~~[dollars] personal needs allowance that shall be retained by the client.

(4) A family care home shall accept as full payment for cost of care the amount of the standard, based on the living arrangement, minus a forty (40) ~~dollar~~[dollars] personal needs allowance that shall be retained by the client.

Section 10.[9-] Temporary Stay in a Medical Facility. (1) An SSI recipient who receives optional or mandatory state supplementation shall have continuation of state supplementation benefits without interruption for the first three (3) full months of medical care in a health care facility if the:

(a) SSI recipient meets eligibility for medical confinement established by 20 C.F.R. 416.212;

(b) Social Security Administration notifies the department that the admission shall be temporary; and

(c) Purpose shall be to maintain the recipient's home or other living arrangement during a temporary admission to a health care facility.

(2) A non-SSI recipient who receives mandatory or optional state supplementation shall have continuation of state supplementation benefits without interruption for the first three (3) full months of medical care in a health care facility if:

(a) The non-SSI recipient meets the requirements of subsection (1)(c) of this section;

(b) A physician certifies, in writing, that the non-SSI recipient is not likely to be confined for longer than ninety (90) full consecutive days; and

(c) A guardian or other payee, personal care home, or family care home, receiving a state supplementation check for the state supplementation recipient, provides a local county department office with:

1. Notification of the temporary admission; and

2. The physician statement specified in paragraph (b) of this subsection.

(3) A temporary admission shall be limited to the following health care facilities:

(a) Hospital;

(b) Psychiatric hospital; or

(c) Nursing facility.

(4) If a state supplementation recipient is discharged in the month following the last month of continued benefits, the temporary absence shall continue through the date of discharge.

Section 11.[10-] Citizenship requirements. An applicant or recipient shall be a:

(1) Citizen of the United States; or

(2) Qualified alien.

Section 12.[11-] Requirement for Residency. An applicant or recipient shall reside in Kentucky.

Section 13.[12-] Mental Illness or Intellectual Disability (MI/ID)[~~Mental Retardation~~ (MI/MR)] Supplement Program. (1) A personal care home:

(a) May qualify, to the extent funds are available, for a quarterly supplement payment of fifty (50) cents per diem for a state supplementation recipient in the personal care home's care as of the first calendar day of a qualifying month;

(b) Shall not be eligible for a payment for a Type A Citation that is not corrected; and

(c) Shall meet the following certification criteria for eligibility to participate in the MI/ID[~~MI/MR~~] Supplement Program:

1. Be licensed in accordance with KRS 216B.010 to 216B.131;

2. Care for a population that is thirty-five (35) percent mental illness or intellectual disability[~~mental retardation~~] clients in all of its occupied licensed personal care home beds and who have a:

a. Primary or secondary diagnosis of intellectual

disability[~~mental retardation~~] including mild or moderate, or other ranges of intellectual disability[~~retardation~~] whose needs can be met in a personal care home;

b. Primary or secondary diagnosis of mental illness excluding organic brain syndrome, senility, chronic brain syndrome, Alzheimer's, and similar diagnoses; or

c. Medical history that includes a previous hospitalization in a psychiatric facility, regardless of present diagnosis;

3. Have a licensed nurse or an individual who has received and successfully completed certified medication technician training on duty for at least four (4) hours during the first or second shift each day;

4. Not decrease staffing hours of the licensed nurse or individual who has successfully completed certified medication technician training in effect prior to July 1990, as a result of this minimum requirement;

5. Be verified by the Office of Inspector General in accordance with Section 15(2)[14(2)] through (4) of this administrative regulation; and

6. File an STS-1, Mental Illness or Intellectual Disability (MI/ID)[~~Mental Retardation~~ (MI/MR)] Supplement Program Application for Benefits, with the department by the tenth working day of the first month of the calendar quarter to be eligible for payment in that quarter.

a. Quarters shall begin in January, April, July, and October.

b. Unless mental illness or intellectual disability[~~mental retardation~~] supplement eligibility is discontinued, a new application for the purpose of program certification shall not be required.

(2) A personal care home shall provide the department with its tax identification number and address as part of the application process.

(3) The department shall provide an STS-2, Mental Illness or Intellectual Disability (MI/ID)[~~Mental Retardation~~ (MI/MR)] Supplement Program Notice of Decision to Personal Care Home, to a personal care home following:

(a) Receipt of verification from the Office of Inspector General as specified in Section 15(6)[14(6)] of this administrative regulation; and

(b) Approval or denial of an application.

(4) A personal care home shall:

(a) Provide the department with an STS-3, Mental Illness or Intellectual Disability (MI/ID)[~~Mental Retardation~~ (MI/MR)] Supplement Program Monthly Report Form, that:

1. Lists every resident of the personal care home who was a resident on the first day of the month;

2. Lists the resident's Social Security number; and

3. Annotates the form, in order to maintain confidentiality, as follows with a:

a. Star indicating a resident has a mental illness or intellectual disability[~~mental retardation~~] diagnosis;

b. Check mark indicating a resident receives state supplementation; and

c. Star and a check mark indicating the resident has a mental illness or intellectual disability[~~mental retardation~~] diagnosis and is a recipient of state supplementation; and

(b) Submit the STS-3 to the department on or postmarked by the fifth working day of the month by:

1. Mail;

2. Fax; or

3. Electronically.

(5) The monthly report shall be used by the department for:

(a) Verification as specified in subsection (4)(a) of this section;

(b) Payment; and

(c) Audit purposes.

(6)(a) A personal care home shall notify the department within ten (10) working days if its mental illness or intellectual disability[~~mental retardation~~] percentage goes below thirty-five (35) percent for all personal care residents.

(b) A personal care home may be randomly audited by the department to verify percentages and payment accuracy.

Section 14. [13-] Mental Illness or Intellectual Disability (MI/ID) [~~Mental Retardation~~] Basic Training. (1)(a) To the extent cabinet

funds are available to support the training, a personal care home's licensed nurse[,] or individual who has successfully completed certified medication technician training shall attend the mental illness or intellectual disability~~[mental-retardation]~~ basic training workshop provided through the Department for Behavioral Health, Developmental and Intellectual Disabilities.

(b) Other staff may attend the basic training workshop in order to assure the personal care home always has at least one (1) certified staff employed for certification purposes.

(2) The mental illness or intellectual disability~~[mental-retardation]~~ basic training shall be provided through a one (1) day workshop. The following topics shall be covered:

(a) Importance of proper medication administration;

(b) Side effects and adverse medication reactions with special attention to psychotropics;

(c) Signs and symptoms of an acute onset of a psychiatric episode;

(d) Characteristics of each major diagnosis, for example, paranoia, schizophrenia, bipolar disorder, or intellectual disability~~[mental-retardation]~~;

(e) Guidance in the area of supervision versus patient rights for the population with a diagnosis of mental illness or intellectual disability~~[mental-retardation]~~; and

(f) Instruction in providing a necessary activity to meet the needs of a resident who has a diagnosis of mental illness or intellectual disability~~[mental-retardation]~~.

(3) Initial basic training shall:

(a) Include the licensed nurse or the individual who has successfully completed certified medication technician training and may include the owner or operator; and

(b) Be in the quarter during which the STS-1 is filed with the department.

(4) To assure that a staff member who has received basic training is always employed at the personal care home, a maximum of five (5) may be trained during a year.

(a) If staff turnover results in the loss of the licensed nurse or individual who has successfully completed certified medication technician training and four (4) other staff have been trained, the personal care home shall request in writing to the department an exemption of the five (5) staff maximum, in order to train another staff member.

(b) A personal care home shall have on staff a licensed nurse or individual who:

1. Has successfully completed certified medication technician training; and

2.a. Has received mental illness or intellectual disability~~[mental-retardation]~~ basic training; or

b. Is enrolled in the next scheduled mental illness or intellectual disability~~[mental-retardation]~~ basic training workshop at the closest location.

(5) The Department for Behavioral Health, Developmental and Intellectual Disabilities may provide advanced level training for a personal care home.

(a) Advanced level training shall be provided through a one (1) day workshop.

(b) Each advanced level workshop shall consist of two (2) sessions per day, and each session shall be three (3) hours in duration.

(c) Each three (3) hour session shall cover a topic appropriate for staff who work with a resident who has a diagnosis of mental illness or intellectual disability~~[mental-retardation]~~.

(d) Attendance of an advanced level training workshop shall be optional.

(6) The Department for Behavioral Health, Developmental and Intellectual Disabilities shall provide within five (5) working days a:

(a) Certificate to direct care staff who complete the training workshop; and

(b) Listing to the department of staff who completed the training workshop.

(7) Unless staff turnover occurs as specified in subsection (4)(a) of this section, the department shall pay twenty-five (25) dollars, to the extent funds are available, to a personal care home:

(a) That has applied for the MI/ID~~[MI/MR]~~ Supplement

Program; and

(b) For each staff member receiving basic or advanced level training up to the maximum of five (5) staff per year.

(8) Attendance of the basic training workshop shall be optional for a specialized personal care home.

Section 15. MI/ID~~14. MI/MR~~ Supplement Program Certification. (1) The Office of the Inspector General shall visit a personal care home to certify eligibility to participate in the MI/ID~~[MI/MR]~~ Supplement Program.

(a) The personal care home's initial MI/ID~~[MI/MR]~~ Supplement Program Certification Survey:

1. May be separate from an inspection conducted in accordance with KRS 216.530; and

2. Shall be in effect until the next licensure survey.

(b) After a personal care home's initial MI/ID~~[MI/MR]~~ Supplement Program Certification Survey is completed, the personal care home may complete any subsequent certification survey during the licensure survey as specified in paragraph (a)2 of this subsection.

(c) The department shall notify the Office of Inspector General that the personal care home is ready for an inspection for eligibility.

(2) During the eligibility inspection, the Office of Inspector General shall:

(a) Observe and interview residents and staff; and

(b) Review records to assure the following criteria are met:

1. Except for a specialized personal care home, certification is on file at the personal care home to verify staff's attendance of basic training, as specified in Section 14(1)~~[13(1)]~~ through (4) of this administrative regulation;

2. The personal care home:

a. Has certified staff training all other direct care staff through in-service training or orientation regarding the information obtained at the mental illness or intellectual disability~~[mental-retardation]~~ basic training workshop; and

b. Maintains documentation of attendance at the in-service training for all direct care staff;

3. Medication administration meets licensure requirements and a licensed nurse or individual who has successfully completed certified medication technician training:

a. Demonstrates a knowledge of psychotropic drug side effects; and

b. Is on duty as specified in Section 13(1)(c)3~~[12(1)(e)3]~~ of this administrative regulation; and

4. An activity is being regularly provided that meets the needs of a resident.

a. If a resident does not attend a group activity, an activity shall be designed to meet the needs of the individual resident, for example, reading or other activity that may be provided on an individual basis.

b. An individualized care plan shall not be required for the criteria in clause a. of this subparagraph.

(3) The Office of Inspector General shall review the personal care home copy of the training certification prior to performing a record review during the MI/ID~~[MI/MR]~~ Supplement Program Certification Survey process.

(4) If thirty-five (35) percent of the population is mental illness or intellectual disability~~[mental-retardation]~~ clients, as specified in Section 13(1)(c)2~~[12(1)(e)2]~~ of this administrative regulation, on the day of the visit, a personal care home shall be deemed to have an ongoing qualifying percentage effective with month of request for certification as specified in subsection (1)(c) of this section.

(5) If the mental illness or intellectual disability~~[mental-retardation]~~ population goes below thirty-five (35) percent of all occupied personal care beds in the facility, the personal care home shall notify the department as specified in Section 13(6)(a)~~[12(6)(a)]~~ of this administrative regulation.

(6) The Office of Inspector General shall provide the department with a completed STS-4, Mental Illness or Intellectual Disability (MI/ID)~~[Mental-Retardation (MI/MR)]~~ Supplement Certification Survey, within fifteen (15) working days of an:

(a) Initial survey; or

(b) Inspection in accordance with KRS 216.530.

(7) The Office of Inspector General shall provide a copy of a Type A Citation issued to a personal care home to the department by the fifth working day of each month for the prior month.

(8) The personal care home shall receive a reduced payment for the number of days the Type A Citation occurred on the first administratively feasible quarter following notification by the Office of Inspector General, in accordance with 921 KAR 2:050.

(9) If a criterion for certification is not met, the department shall issue an STS-2 to a personal care home following receipt of the survey by the Office of Inspector General as specified in subsection (6) of this section.

(10) The personal care home shall provide the department with the information requested on the STS-2:

(a) Relevant to unmet certification criteria specified on the STS-4; and

(b) Within ten (10) working days after the STS-2 is issued.

(11) If a personal care home fails to provide the department with the requested information specified in subsection (10) of this section, assistance shall be discontinued or decreased, pursuant to 921 KAR 2:046.

(12) If a personal care home is discontinued from the MI/ID[MI/ID]/MI/ID Supplement Program, the personal care home may reapply for certification, by filing an STS-1 in accordance with Section 13(1)(c)6[12(1)(c)6] of this administrative regulation, for the next following quarter.

Section 16.[15.] Hearings and Appeals. An applicant or recipient of benefits under a program described in this administrative regulation who is dissatisfied with an action or inaction on the part of the cabinet shall have the right to a hearing under 921 KAR 2:055.

Section 17.[16.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "STS-1, Mental Illness or Intellectual Disability (MI/ID)[Mental Retardation (MI/ID)] Supplement Program Application for Benefits", 01/14[edition 1/09];

(b) "STS-2, Mental Illness or Intellectual Disability (MI/ID)[Mental Retardation (MI/ID)] Supplement Program Notice of Decision to Personal Care Home", 01/14[edition 1/09];

(c) "STS-3, Mental Illness or Intellectual Disability (MI/ID)[Mental Retardation (MI/ID)] Supplement Program Monthly Report Form", 01/13/14[01/14][edition 1/09]; and

(d) "STS-4, Mental Illness or Intellectual Disability (MI/ID)[Mental Retardation (MI/ID)] Supplement Certification Survey", 01/13/14[01/14][edition 1/12].

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

TERESA C. JAMES, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: November 6, 2013

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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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Community Based Services
Division of Family Support
(As Amended at ARRS, January 13, 2014)

921 KAR 3:090. Simplified assistance for the elderly program or "SAFE".

RELATES TO: 7 C.F.R. 273.1, 273.2, 273.9, 273.10, 273.12, 273.14

STATUTORY AUTHORITY: KRS 194A.050(1), 7 C.F.R. 271.4
 NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.050(1) requires the secretary of the Cabinet for Health and

Family Services to promulgate administrative regulations necessary to 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. 7 C.F.R. 271.4 delegates the administration of the Supplemental Nutrition Assistance Program (SNAP) to the state agency. This administrative regulation establishes requirements for the Simplified Assistance for the Elderly Program (SAFE), a demonstration project administered by the cabinet to improve access to SNAP for elderly and disabled individuals.

Section 1. Definitions. (1) "Regular SNAP benefits" means SNAP benefits received in accordance with the procedures specified in:

(a) 921 KAR 3:020, Financial Requirements;

(b) 921 KAR 3:025, Technical Requirements;

(c) 921 KAR 3:030, Application Process; and

(d) 921 KAR 3:035, Certification Process.

(2) "Shelter costs" means monthly rent or mortgage expenses as stated by the applicant.

(3) "Simplified Assistance for the Elderly" or "SAFE" means an optional SNAP program for SSI participants who are age sixty (60) or older.

(4) "State Data Exchange" or "SDX" means files administered by the Social Security Administration that provide states with eligibility and demographic data relating to SSI applicants and participants.

Section 2. SAFE Program Procedures. Unless a different procedure or process for a SNAP requirement is specified in this administrative regulation, all SNAP requirements specified in 921 KAR Chapter 3 shall apply to SAFE, including the process for:

(1) A fair hearing;

(2) An administrative disqualification hearing;

(3) An appeal;

(4) A disqualification;

(5) A claim and collection of a claim; and

(6) EBT issuance.

Section 3. Eligibility for SAFE. (1) An individual may qualify for SAFE benefits if the individual:

(a) Is a Kentucky resident;

(b) Is:

1. A current SSI recipient; or

2. SSI eligible, but SSI benefits are currently suspended[in suspense];

(c) Is age sixty (60) or older;

(d) Is not institutionalized;

(e) Is:

1. Single, widowed, divorced, or separated; or

2. Married and living with a spouse who meets the criteria specified in (a) through (f) of this subsection; and

(f) Purchases and prepares food separately from another individual who[if the other individual] shares the same residence, but is not a member of the applicant's household as defined in 921 KAR 3:010.

(2) The cabinet shall use SDX to verify an applicant's marital and institutional status.

(3) If a household member does not meet the criteria listed in subsection (1) of this section, the household:

(a) Shall not be eligible for SAFE; and

(b) May apply for regular SNAP benefits in accordance in 921 KAR 3:030.

(4) An individual who meets the criteria of subsection (1) of this section may apply for regular SNAP benefits instead of SAFE benefits.

(5) An individual shall not receive SAFE benefits and regular SNAP benefits at the same time.

Section 4. SAFE Application Process. (1) Through use of the SDX files, the cabinet shall:

(a) Identify SSI participants who are potentially eligible for

SAFE; and

(b) Mail each identified SSI household a SF-1, Simplified Assistance for the Elderly (SAFE) Application, and a return envelope.

(2) A SAFE application shall be considered filed if the SF-1 is:

(a) Signed; and

(b) Received at the Department for Community Based Services, Division of Family Support.

(3) In accordance with 7 C.F.R. 273.2(g), the cabinet shall provide an eligible household an opportunity to participate within thirty (30) days of the date the application is filed.

Section 5. SAFE Certification Process. (1) The cabinet shall process a SAFE application without requiring an interview.

(2) Information necessary to certify a SAFE application shall be obtained from SDX with the exception of the information provided by the applicant on the SF-1 or the SF-2, Simplified Assistance for the Elderly (SAFE) Recertification Form.

(3) The cabinet shall certify an eligible household for SAFE benefits for up to thirty-six (36) months.

(4) In accordance with 7 C.F.R. 273.10(g), the cabinet shall send an applicant a notice upon certification or denial.

(5) The cabinet shall send a SF-2 to a SAFE household in the month preceding the last month of the household's certification period.

Section 6. SAFE Benefits. (1) The cabinet shall provide a SAFE household a standard monthly benefit amount approved by the U.S. Department of Agriculture's Food and Nutrition Service and listed in the SF-1 and listed in the SF-1].

(2) The standard SAFE benefit amounts shall be based on:

(a) Shelter costs;

(b) Household size; and

(c) The average benefits received by a similar household in the regular SNAP.

Section 7. Changes in Household Circumstances. (1) A household receiving SAFE benefits shall not be required to report any changes during the certification period.

(2) The cabinet shall process changes in household circumstances based on information received from SDX.

(3) If information voluntarily reported by the household is contradictory to SDX data, the cabinet shall not act upon the information unless the information is a change in a household member's:

(a) Name;

(b) Date of birth; or

(c) Address.

(4) Unless a change in household circumstance results in a change in benefits, the cabinet shall not provide a SAFE household with notification of a change being made in household circumstances.

Section 8. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "SF-1, Simplified Assistance for the Elderly (SAFE) Application", 11/13[04/13]; and

(b) "SF-2, Simplified Assistance for the Elderly (SAFE) Recertification Form", 04/13.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Community Based Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.
921 KAR 3:090

TERESA C. JAMES, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: October 22, 2013

FILED WITH LRC: October 30, 2013 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.

**ADMINISTRATIVE REGULATIONS AMENDED AFTER PUBLIC HEARING
OR RECEIPT OF WRITTEN COMMENTS**

**JUSTICE AND PUBLIC SAFETY CABINET
Department of Juvenile Justice
(Amended After Comments)**

**505 KAR 1:170. Department of Juvenile Justice Policies
and Procedures: Prison Rape Elimination Act of 2003 (PREA).**

RELATES TO: KRS 15A.065, 15A.067, Chapters 600-645
STATUTORY AUTHORITY: KRS 15A.065, 15A.067, 15A.160,
15A.210, 200.115, 605.100, 605.150, 635.095, 640.120, 645.250
NECESSITY, FUNCTION, AND CONFORMITY: KRS
15A.065(1), 15A.067, 15A.160, 15A.210, 15A.305(5), 605.100,
605.150, 635.095, 640.120, and 645.250 authorize the Justice and
Public Safety Cabinet and the Department of Juvenile Justice to
promulgate administrative regulations for the proper administration
of the cabinet and its programs. This administrative regulation
incorporates by reference into regulatory form materials used by
the Department of Juvenile Justice in the implementation of a
statewide juvenile services program.

Section 1. Incorporation by Reference. (1) The "Department of
Juvenile Justice Policies and Procedures: "Prison Rape Elimination
Act of 2003 (PREA)", January 15, 2014~~[(October 14, 2013)]~~, is
incorporated by reference and includes the following:

- 900 Definitions (January 15, 2014)~~[(October 14, 2013)]~~;
- 901 Zero Tolerance of Any Type of Sexual Misconduct
(January 15, 2014)~~[(October 14, 2013)]~~;
- 902 Personnel Procedures (January 15, 2014)~~[(October 14,
2013)]~~;
- 903 Prohibited Conduct of Staff, Interns, Volunteers, and
Contractors (January 15, 2014)~~[(October 14, 2013)]~~;
- 904 Contracted Residential Entities (October 14, 2013);
- 905 Juvenile Vulnerability Assessment Procedure (January
15, 2014)~~[(October 14, 2013)]~~;
- 906 Reporting and Investigating PREA Violations (January
15, 2014)~~[(October 14, 2013)]~~;
- 907 Resident PREA Education (January 15, 2014)~~[(October
14, 2013)]~~;
- 908 DJJ Response to a Report of a PREA Violation
(January 15, 2014) ~~[(October 14, 2013)]~~;
- 909 Data Collection and Review (January 15,
2014)~~[(October 14, 2013)]~~;
- 910 Facility Security Management (October 14, 2013);
- 911 DJJ Staff PREA Education and Training (October 14,
2013); and
- 912 Sexual Orientation and Gender Identity (January 15,
2014)~~[(October 14, 2013)]~~.

(2) This material may be inspected, copied, or obtained,
subject to applicable copyright law, at the Department of Juvenile
Justice, Office of the Commissioner, 1025 Capital Center Drive,
Third Floor, Frankfort, Kentucky 40601, or at any department field
office, Monday through Friday, 8 a.m. to 4:30 p.m.

A. HASAN DAVIS, Commissioner

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 15, 2014 at 9 a.m.

CONTACT PERSON: LaDonna Koebel, Staff Attorney,
Department of Juvenile Justice, 1025 Capital Center Drive,
Frankfort, Kentucky 40601, phone (502) 573-2738, fax (502) 573-
0836.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: LaDonna Koebel

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation
incorporates by reference the policies and procedures governing
the Kentucky Department of Juvenile Justice, including the rights
and responsibilities of employees and the juvenile population.

(b) The necessity of this administrative regulation: To comply
with the requirements of 28 C.F.R. §115, Subpart D.

(c) How this administrative regulation conforms to the content
of the authorizing statutes: The regulation governs the operations
of the Kentucky Department of Juvenile Justice.

(d) How this administrative regulation currently assists or will
assist in the effective administration of the statutes: This new
administrative regulation and material incorporated by reference
establishes policies and procedures that govern the operations of
the Kentucky Department of Juvenile Justice and its facilities. It
provides direction and information to departmental employees and
juveniles concerning the operations of the department.

(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 new administrative regulation will bring the
Kentucky Department of Juvenile Justice into compliance with the
federal requirements of the Prison Rape Elimination Act of 2003
(PREA) and updates current practices for the department,
employees, and juveniles in the care and custody of the
department.

(b) The necessity of the amendment to this administrative
regulation: To comply with the requirements of 28 C.F.R. §115,
Subpart D.

(c) How the amendment conforms to the content of the
authorizing statutes: The regulation governs the operations of the
Kentucky Department of Juvenile Justice.

(d) How the amendment will assist in the effective
administration of the statutes: This new administrative regulation
and material incorporated by reference establishes policies and
procedures that govern the operations of the Kentucky Department
of Juvenile Justice and its facilities. It provides direction and
information to departmental employees and juveniles concerning
the operations of the department.

(3) List type and number of individuals, businesses,
organizations, or state and local governments affected by this
administrative regulation: This regulation affects the Kentucky
Department of Juvenile Justice, fourteen hundred (1400)
employees, all juveniles committed to the care and custody of the
department, visitors, volunteers, interns, and contractors.

(4) Provide analysis of how the entities identified in question
(3) will be impacted by the implementation of this 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. Staff, volunteers, interns, and
contractors will be required to follow the incorporated policies and
procedures. Juveniles in the care and custody of the Kentucky
Department of Juvenile Justice will have the rights established by
the policy.

(b) In complying with this administrative regulation or
amendment, how much will it cost each of the entities identified in
question (3): An exact cost of compliance is unknown, but it is not
anticipated that this new administrative regulation will increase
current costs significantly.

(c) As a result of compliance, what benefits will accrue to the
entities identified in question (3): The impact of the policies and
procedures will protect rights of juveniles in the care and custody of
the dept. and further ensure safety and protection of youth.

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

(a) Initially: The department anticipates that any initial cost will
be related to training staff, volunteers, interns, and contractors on
the new policies and the requirements of PREA.

(b) On a continuing basis: The cost associated with complying
with the stipulations and federal requirements will primarily come
from mandatory audits of department programs. The U.S.
Department of Justice has not yet identified cost associated with
audits, but such audits are anticipated to be in line with ACA

audits, approximately \$25,000 per year.

(6) What is the source of funding to be used for the implementation and enforcement of this administrative regulation: Kentucky Department of Juvenile Justice budgeted funds for the biennium.

(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 is anticipated; however it is anticipated that an increase in funding may be necessary to cover the costs of the federally required audits. The cost of the audits is currently unknown but is anticipated to be approximately \$25,000 per year.

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

(9) Tiering: Is tiering applied? No. Tiering is not appropriate in this new 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 regulation impacts operation of the Kentucky Department of Juvenile Justice and its facilities.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 15A.065, 15A.067, 15A.160, 15A.160, 200.115, 605.11, 605.150, 640.120, 645.450, 28 C.F.R. §115, Subpart D.

(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? Not applicable.

(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? Not applicable.

(c) How much will it cost to administer this program for the first year? The department anticipates that any initial cost will be related to training staff, volunteers, interns, and contractors on the new policies and the requirements of PREA.

(d) How much will it cost to administer this program for subsequent years? The cost associated with complying with the stipulations and federal requirements will primarily come from mandatory audits of department programs. The U.S. Department of Justice has not yet identified cost associated with audits, but such audits are anticipated to be in line with ACA audits, approximately \$25,000 per year.

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

Revenues (+/-): No revenue will be generated from this regulation.

Expenditures (+/-): Expenditures relate to training staff and auditing programs to ensure compliance.

Other Explanation:

PUBLIC PROTECTION CABINET Kentucky Department of Insurance Property and Casualty Division (Amended After Comments)

806 KAR 39:070. Proof of motor vehicle insurance.

RELATES TO: KRS 186.021(3), 186A.040, 186A.042,

186A.095, 304.39-080, 304.39-083, 304.39-085, 304.39-087, 304.39-090, 304.39-117

STATUTORY AUTHORITY: KRS 186.021(3), ~~186A.042,~~ 304.2-110(1), ~~304.39-083, 304.39-085, 304.39-087,~~ 304.39-117(1), 304.39-300

NECESSITY, FUNCTION, AND CONFORMITY: KRS 186.021(3) requires the commissioner[Executive Director] of the Department[Office] of Insurance to promulgate an administrative regulation to establish the manner for presenting proof of motor vehicle insurance to a county clerk. **KRS 304.2-110(1) and 304.39-300 authorize the commissioner to promulgate administrative regulations necessary for or as an aid to enforce the insurance code.** KRS 304.39-117(1) requires the Department[Office] of Insurance to promulgate an administrative regulation that establishes the requirements for the proof of insurance[card] that an insurer shall[is required to] give to an insured. **[KRS 186A.042 requires the vehicle owner to present proof of insurance to the county clerk if the Department of Vehicle Regulation's database does not confirm coverage. KRS 304.39-083,] and [304.39-085, and 304.39-087 require the Department of Insurance to promulgate an administrative regulation to establish the manner for insurers to electronically report motor vehicle insurance information to the Department of Vehicle Regulation and to notify] [notification to] [the Department of Vehicle Regulation if a binder or other contract for temporary insurance or a commercial policy is terminated by cancellation or nonrenewal].** This administrative regulation establishes the requirements for the proof of insurance[card]; the methods for reporting coverage provided for personal motor vehicles insured on a personal lines motor vehicle policy[.]; the methods for presenting proof of motor vehicle insurance to a county clerk or peace officer; and the requirements for notifying the Department of Vehicle Regulation if a binder, contract, or commercial policy of motor vehicle insurance is cancelled or not renewed.

Section 1. Definitions. (1) "Commissioner"["Executive director"] is defined by KRS 304.1-050(1).

(2) "Department" is defined by KRS 304.1-050(2).

(3) "Insurer" means an insurer under KRS 304.1-040~~or self-insurer who provides security covering a motor vehicle pursuant to KRS 304.39-080~~.

(4)[(3)] "Motor vehicle insurance policy" means an insurance contract that provides security covering a motor vehicle required to be registered pursuant to KRS 186.020 and insured pursuant to KRS 186.021 and 304.39-080. [(4) "Office" is defined by KRS 304.1-050(2).]

(5) "Person" is defined by KRS 304.1-020.

(6) "Personal lines motor vehicle policy" means[is] an insurance policy, issued by an insurance carrier authorized to do business in the Commonwealth of Kentucky, which insures a personal motor vehicle.

(7) "VIN" means the vehicle identification number of a motor vehicle.

Section 2. Proof of Insurance[Card] to be Provided by Insurers.

(1) The proof of insurance[card] required by KRS 304.39-117 shall be provided to the insured when[at the time] a policy is issued, renewed, or amended to include a vehicle. An insurer electing to provide proof of insurance in an electronic format shall provide a printed proof of insurance unless the insured requests to receive proof of insurance in electronic format.

(2) Printed proof of[Copies of the] insurance card.

(a)[If the motor vehicle insurance policy covers four (4) or less vehicles, a single insurance card shall be provided for each motor vehicle.] Two (2) copies of the printed proof of insurance card shall be provided for each motor vehicle insured under a motor vehicle insurance policy.

(b) Guidelines for size and format of the printed proof of insurance card.

1. The printed proof of insurance card shall be:

a. A two and one-fourth (2 1/4) inch by three and one-half (3 1/2) inch card;

b. A two and one-fourth (2 1/4) inch by seven (7) inch card with a vertical fold resulting in a two and one-fourth (2 1/4) inch by three and one-half (3 1/2) inch card; or

c. A four and one-half (4 1/2) inch by three and one-half (3 1/2) inch card with a horizontal fold resulting in a two and one-fourth (2 1/4) inch by three and one-half (3 1/2) inch card.

2. The printed insurance card may vary slightly from the dimension requirements established in subparagraph 1. of this paragraph.

3. The printed insurance card shall be on white paper with black or blue ink. If the motor vehicle insurance policy covers five (5) or more vehicles, a copy of the insurance card shall be provided for each vehicle covered by the policy. Sufficient copies of the insurance card shall be provided to the policyholder so that the policyholder will have a single insurance card for the county clerk of each county in which the policyholder has motor vehicles registered.

(3) Proof of insurance in an electronic format.

(a) Proof of insurance in an electronic format shall ~~be~~include the display of an image on any portable electronic device, including a cellular phone or other device, depicting a current, valid, and in-force policy. The image shall have been downloaded from or transmitted by the insurer or agent to the insured.

(b) Proof of insurance in an electronic format shall not include a photographic copy of a paper insurance card on a portable electronic device. [Guidelines for size and format of the insurance card.]

(a) The insurance card shall be:

1. A two and one-fourth (2 1/4) inch by three and one-half (3 1/2) inch card;

2. A two and one-fourth (2 1/4) inch by seven (7) inch card with a vertical fold resulting in a two and one-fourth (2 1/4) inch by three and one-half (3 1/2) inch card; or

3. A four and one-half (4 1/2) inch by three and one-half (3 1/2) inch card with a horizontal fold resulting in a two and one-fourth (2 1/4) inch by three and one-half (3 1/2) inch card.

(b) The insurance card may vary slightly from the dimension requirements established in paragraph (a) of this subsection.

(c) The insurance card shall be on white paper with black or blue ink.

(4) Mandatory contents of the proof of insurance[card]. In either paper or electronic format, the proof of insurance[card] shall prominently display[on its face] the following information, [to appear] in the order listed:

(a) Title[of the document]: "COMMONWEALTH OF KENTUCKY PROOF OF INSURANCE[-]";

(b) The name of the insurance company and its five (5) digit code number assigned by the National Association of Insurance Commissioners (NAIC), or the name of the Self-Insured Group and the group ID number provided by the department[DOI];

(c) The name of the named insured[-];

(d) The effective date and expiration date of coverage. If the policy[card] is amended to add an identified vehicle[issued] midterm, the effective date on the card shall be[indicate] the effective date of the amendment[coverage if different than the inception date of the policy];

(e) The policy number[-];

(f) The type of policy;

1. If the policy is a personal lines motor vehicle policy for which premium is reported on the NAIC Annual Statement line 19.1 or 19.2, the insurer shall indicate the policy type as "Personal" or "PL"; or

2. If the policy is a commercial lines motor vehicle policy for which premium is reported on the NAIC Annual Statement line 19.3 or 19.4, the insurer shall indicate the policy type as "Commercial" or "CL"; and

(g) The vehicle(s) insured:

1. If the type of policy is personal lines (PL), [insurance contract covers four (4) or fewer vehicles,] the [motor vehicle identification:] year, make, [or] model, and VIN of each motor vehicle.

2. If the type of policy is commercial lines (CL)[-];

a. If the insurance contract covers four (4) or fewer vehicles,

the year, make, model and VIN of each motor vehicle.

b. If the insurance contract covers five (5) or more motor vehicles, it may[shall] state "Fleet" or[-] the insurer may elect to include the [motor vehicle identification:] year, make, [or] model, and the VIN of each motor vehicle.

(5) Other information to be provided to the insured. The insurer shall:

(a) Include the following information on the proof of insurance[card] if the information required by subsection (4) of this section is not obscured:

1. The insurer's logo;

2. A statement that establishes the procedure for contacting the insurer concerning a claim; and

3. The insurer's address; or

(b) Include the information listed in paragraph (a) of this subsection on a separate document or electronic image provided[mailed] with the proof of insurance[card].

(6) An insurer shall furnish with the proof of insurance[card] the following [written] information:

(a) Instructions that the insured shall keep a copy of the proof of insurance[card] in each motor vehicle covered by the policy at all times;

(b) Information as to whether or not the policy is a personal lines motor vehicle policy and whether or not the vehicle has been reported as an insured personal motor vehicle;

1. If so, the insured shall be informed that:

a. The proof of coverage information has been reported electronically to the Department of Vehicle Regulation; and

b. If the VIN does not appear in the database, the insured may be required to present proof of[a copy of the] insurance [card] to the county clerk for issuance of a replacement plate, decal, or registration certificate or renewal as alternative evidence of proof of coverage; or

2. If not, the insured shall be instructed to present proof of[a copy of the] insurance [card] to the county clerk for issuance of a replacement plate, decal, or registration certificate or renewal as evidence of proof of coverage; and

(c) Instructions to compare the VIN appearing on the registration, insurance policy and proof of insurance[card] to the VIN affixed to the vehicle.

1. If the VIN on the motor vehicle title and registration and the VIN on the motor vehicle do not match, the policyholder shall contact the county clerk to have the title and registration corrected;

2. If the VIN on the proof of insurance[card] and the motor vehicle do not match, the policyholder shall contact the insurer to have the insurance policy and card corrected. The insurer shall provide the name, address, and telephone number of an insurer representative to contact concerning a discrepancy. The telephone number shall be:

a. The phone number of a local agent of the insurer; or

b. A toll-free telephone number of the insurer.

Section 3. Methods of Proving Motor Vehicle Insurance. One (1) of the following methods shall be used to prove that motor vehicle insurance is in effect when registering a motor vehicle:

(1) The VIN appears as an insured motor vehicle in the Department of Vehicle Regulation's database;

(2) Proof of[A copy of the] current insurance in paper or electronic format;

(a) If the database does not list the VIN of a vehicle insured on a personal lines motor vehicle (PL) policy, the proof of coverage shall[must] indicate the proof was effective no more than forty-five (45) days prior to submission to the county clerk; and

(b) The county clerk may require the proof of coverage to be sent directly to the clerk by the agent or company[card];

(3) A certificate of insurance issued by an insurance agent with a casualty line of authority licensed by Kentucky;

(4) An insurance contract with a declaration page attached showing that the policy is in effect when[at the time] the motor vehicle is being registered or transferred;

(5) A letter from the Kentucky Automobile Insurance Plan serving as prima facie evidence of insurance in force; [or]

(6) If the owner of the motor vehicle is serving in the armed

forces outside Kentucky, an affidavit by the provost marshal of the base where the person is stationed stating that the motor vehicle is covered by an automobile liability insurance policy; or.]

(7) A letter from the Kentucky Department [Office] of Insurance serving as prima facie evidence of self-insurance pursuant to KRS 304.39-080(7).

Section 4. Beginning January 1, 2006, and each month thereafter, an insurer shall submit information on each vehicle covered by a personal lines motor vehicle policy according to the rules contained in Section 2.1 of the Kentucky Automobile Liability Insurance Reporting Guide.

Section 5. For motor vehicles insured under a commercial lines or fleet policy, each insurer [all insurers] shall report cancellations pursuant to Part 2.2 of the Kentucky Automobile Liability Insurance Reporting Guide.

Section 6. An insurance agent shall submit to the Department of Vehicle Regulation a completed Form TC96-30 if the purchaser of a binder or temporary insurance contract cancels the binder or contract before the agent has submitted the application to the insurance company.

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

(a) "Kentucky Automobile Liability Insurance Reporting Guide", Transportation Cabinet, Department of Vehicle Regulation (Version 1.6, 8/15/2005 edition); and

(b) "Form No. TC96-30, Motor Vehicle Insurance Agent Insurance Binder Cancellation Form (5/05 edition)", Kentucky Transportation Cabinet, Department of Motor Vehicle Regulation.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Vehicle Regulation, P. O. Box 2014, 200 Mero Street, Frankfort, Kentucky 40622, Monday through Friday, 8 a.m. to 4:30 p.m. The material may also be obtained at the Transportation Cabinet Web site: <http://transportation.ky.gov/mvl/home.htm>. The material may also be obtained at the Department of Insurance Web site: <http://insurance.ky.gov>.

SHARON P. CLARK, Commissioner

ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at noon

CONTACT PERSON: D.J. Wasson, Staff Assistant, Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, phone (502) 564-6026, fax (502) 564-1453.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: D.J. Wasson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the requirements for proof of motor vehicle insurance, the methods for reporting coverage provided for personal motor vehicles insured on a personal lines motor vehicle policy, the methods for presenting proof of motor vehicle insurance to a county clerk or peace officer, and the requirements for notifying the Department of Vehicle Regulation if a binder, contract, or commercial policy of motor vehicle insurance is cancelled or not renewed.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the manner for presenting proof of motor vehicle insurance to a county clerk, to establish the requirements for the proof of motor vehicle insurance that an insurer is required to give to an insured, and to establish how an insurer or agent is to notify the Department of Vehicle Regulation if a binder, other contract for temporary insurance, or a policy is terminated by cancellation or nonrenewal.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 186.021 requires the Commissioner of the Department of Insurance to promulgate an

administrative regulation to establish the manner for presenting proof of motor vehicle insurance to a county clerk. KRS 304.39-117 requires the Department of Insurance to promulgate an administrative regulation that establishes the requirements for the proof of insurance that an insurer is required to give to an insured. KRS 304.39-083 and 304.39-085 require notification to the Department of Vehicle Regulation if a binder or other contract for temporary insurance or a policy is terminated by cancellation or nonrenewal.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation informs all insurers regulated by the Department of Insurance of the policies and procedures for providing proof of insurance in conformity with the intent of the statutes. This administrative regulation informs County Clerks of the acceptable means of proof of insurance.

(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 reflects prior reorganization of the Public Protection Cabinet, sets out the required contents of both paper and electronic proof of insurance and restores the requirement that the paper or electronic image format must be submitted to the Department of Insurance, Property and Casualty Division for approval as a policy form.

(b) The necessity of the amendment to this administrative regulation: KRS 304.39-117 was amended by 13 RS HB 164, effective June 25, 2013 to permit proof of insurance to be provided and presented electronically. The current regulation only addresses printed proof of insurance cards. This amendment adds requirements to the contents of the proof of insurance to facilitate administration of KRS 186A.042 by county clerks.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 186.021 requires the Commissioner of the Department of Insurance to promulgate an administrative regulation to establish the manner for presenting proof of motor vehicle insurance to a county clerk. KRS 304.39-117 requires the Department of Insurance to promulgate an administrative regulation that establishes the requirements for the proof of insurance that an insurer is required to give to an insured. KRS 304.39-083 and 304.39-085 require notification to the Department of Vehicle Regulation if a binder or other contract for temporary insurance or a policy is terminated by cancellation or nonrenewal.

(d) How the amendment will assist in the effective administration of the statutes: The amendments to this administrative regulation inform all insurers and producers regulated by the Department of Insurance of the proof of insurance which must be provided to the each vehicle owner, the methods by which a vehicle owner shall present proof of insurance to their county clerk or a peace officer, and the methods by which the insurers and producers shall report coverage information to the Transportation Cabinet's Department of Vehicle Regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Every motor vehicle insurer issuing a policy which covers a vehicle registered in Kentucky must provide proof of insurance for each insured vehicle. There are approximately 319 motor vehicle liability insurers writing liability coverage in Kentucky in 2012. There are 3,784,901 registered motor vehicles, 3,186,199 personal vehicles with in force coverage in Kentucky. There have been 172,240 (5.4%) uninsured personal vehicles identified by the electronic system since April 30, 2012, which was implemented statewide in June 2012. There are approximately 38,400 licensed producers (agents), and 120 county clerks. The number of peace officers throughout the state is unknown.

(4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment: All of the above groups are currently impacted by the current administrative regulation. Specifically regarding the amendments, some insurers will be interested in providing electronic proof of insurance apps to their customers as the insurers already deliver

policies and complete transactions electronically.

(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: In order to comply with this administrative regulation, insurers wanting to offer electronic proof of insurance need to ensure that the proof of insurance is available for download to a customer's portable electronic device in a manner that depicts current, valid, in-force coverage. Consumers opting to use electronic proof of insurance need to ensure that they maintain proof of coverage, whether electronic or paper, in their vehicle at all times. Law enforcement and county clerks need to be aware that electronic proof of insurance meeting the requirements of this administrative regulation is an appropriate manner to demonstrate that insureds have met their obligation to maintain insurance on their motor vehicle.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There is no additional cost to law enforcement or county clerks to implement this administrative regulation. Because offering electronic proof of insurance is optional, there is no cost to an insurer. For insurers that voluntarily choose to offer electronic proof of insurance, the costs will vary based on their current system capabilities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The primary benefits of offering electronic proof of insurance are the ability of insurers to streamline business operations by using less paper and the ability of consumers to use current technology to fulfill their ability to demonstrate motor vehicle insurance.

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

(a) Initially: There will be no cost to implement, no mass mailing, no new filings, and no additional staff needed. The P&C Division will alert insurers via SERFF about the reg revisions. A notice will also be prepared to inform Transportation and the county clerks.

(b) On a continuing basis: There is no additional cost to DOI to implement this regulation on an ongoing basis. Insurers are not currently required to file the printed proof of insurance, nor will they be required to file a printed image of the optional electronic proof of insurance.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The implementation and enforcement of the amendments to this administrative regulation will continue to be funded by the existing filing fees charged by the Department of Insurance pursuant to 806 KAR 4:010.

(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 increase in fees or funding necessary to implement the amendments to this administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: The amendments to this administrative regulation do not establish any new fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is applied by the statutory distinctions between personal and commercial motor vehicle policies.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Department of Insurance as the implementer of the regulation and, specifically, the Department's Property and Casualty Division.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 186.021, 186A.042, 304.2-110(1), 304.39-083, 304.39-085, 304.39-087, 304.39-117, 304.39-300

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 revenue for the Department of Insurance 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? This administrative regulation will not generate revenue for the Department of Insurance for subsequent years.

(c) How much will it cost to administer this program for the first year? There should not be a cost to administer this program in the first year.

(d) How much will it cost to administer this program for subsequent years? There should not be a cost to administer this program in subsequent years.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation: The amendments to this administrative regulation permit insurers to offer proof of motor vehicle coverage through an electronic format. The department will enforce these requirements through its existing complaint process.

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Commissioner's Office

(Amended After Comments)

907 KAR 20:001. Definitions for 907 KAR Chapter 20.

RELATES TO: KRS 194A.025(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

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. This administrative regulation establishes the definitions for 907 KAR Chapter 20.

Section 1. Definitions. (1) "1915(c) home and community based service" means a service available or provided via a 1915(c) home and community based services waiver program.

(2) "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).

(3) "ABD" means a person who is aged, blind, or disabled.

(4) "Adult scale" means the scale located in 907 KAR 20:020, Section 2(1), establishing Medicaid income limits by family size.

(5) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(6) "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).

(7) "AFDC-related case" means a Medicaid-eligible, categorically-needy individual or group based upon AFDC Program requirements effective since July 16, 1996.

(8) "After the month of separation" means the first day of the month that follows the month in which an individual ceases living in

the same household of a Medicaid eligible family.

(9) "Aged" means at least sixty-five (65) years of age.

(10) "Aid and Assistance" or "A & A" means a benefit to a United States veteran:

- (a) In addition to the individual's monthly pension; and
- (b) Paid by the United States Veterans Administration.

(11) "Aid to Families with Dependent Children" or "AFDC" means an assistance program:

- (a) In effect from 1935 to 1996;
- (b) For children whose families had low or no income; and
- (c) Administered by the United States Department of Health and Human Services.

(12) "Ambulatory prenatal care" means health-related care furnished to a presumed eligible pregnant woman provided in an outpatient setting.

(13) "Appeal" means a request for review of an adverse action or a decision by an MCO related to a covered service.

(14) "Applicant" means an individual applying for Medicaid.

(15) "Authorized representative" means:

(a) For a recipient or applicant who is authorized by Kentucky law to provide written consent, an individual or entity acting on behalf of, and with written consent from, the applicant or recipient; or

(b) A legal guardian.

(16) "Baseline date" means the date the institutionalized individual was institutionalized and applied for Medicaid.

(17) "Basic maintenance" means the amount of income that may be retained by the applicant for living and personal expenses.

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

(19) "Blind work expense" or "BWE" means an SSI program option in which expenses a blind individual incurs in order to earn income are deducted for SSI eligibility purpose.

(20) "Cabinet" is defined by KRS 194A.005(1).

(21) "Caretaker relative" means:

(a) An individual:

1. Who is the caregiver of a child under the age of nineteen (19) years; or

2. On whose tax return the child under the age of nineteen (19) years is listed as a dependent; and

(b) **Who has** one (1) of the following **relationships to the child:**

- 1. A grandfather;
- 2. A grandmother;
- 3. A brother;
- 4. A sister;
- 5. An uncle;
- 6. An aunt;
- 7. A nephew;
- 8. A niece;
- 9. A first cousin;
- 10. A relative of the half-blood;
- 11. A preceding generation denoted by a prefix of:
 - a. Grand;
 - b. Great; or
 - c. Great-great; or
- 12. A stepfather, stepmother, stepbrother, or stepsister.

(22) "Categorically needy" means an individual with income below 300 percent of the supplemental security income (SSI) standard who has been receiving hospice or 1915(c) home and community based services for at least thirty (30) consecutive days.

(23) "CDC" means the federal Centers for Disease Control and Prevention.

(24) "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.

(25) "Community spouse" means the spouse of an institutionalized spouse who:

- (a) Remains at home in the community; and
- (b) Is not:

- 1. Living in a medical institution;
- 2. Living in a nursing facility; or
- 3. Participating in a 1915(c) home and community based services waiver program.

(26) "Community spouse maintenance standard" means the income standard to which a community spouse's otherwise available income is compared for purposes of determining the amount of the allowance used in the post-eligibility calculation.

(27) "Continuous period of institutionalization" means thirty (30) or more consecutive days of institutional care in a medical institution or nursing home or both and may include thirty (30) consecutive days of receipt of a 1915(c) home and community based service or a combination of both.

(28) "Countable resources" means resources not subject to exclusion in the Medicaid Program.

(29) "Creditable coverage" is defined in KRS 304.17A-005(7).

(30) "DCBS" means the Department for Community Based Services.

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

(32) "Dependent child" means a **natural[couple's]** child, including a child gained through adoption, who:

(a) Lives with a **parent in** the community[spouse]; and

(b) Is claimed as a dependent by either **parent[spouse]** under the Internal Revenue Service Code.

(33) "Dependent parent" means a parent:

(a) Of either member of a couple;

(b) Who lives with the community spouse; and

(c) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(34) "Dependent sibling" means a brother or sister of either member of a couple, including a half-brother, half-sister, or sibling gained through adoption, who:

(a) Resides with the community spouse; and

(b) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(35) "Designated hearing agency" means the Department for Community Based Services.

(36) "Disabled" is defined by 42 U.S.C. 1382c(a)(3).

(37) "Dual eligible" means an individual eligible for Medicare and Medicaid benefits.

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

(39) "Emergency service" means "emergency services" as defined by 42 U.S.C. 1396u-2(b)(2)(B).

(40) "Enrollee" means a recipient who is enrolled with a managed care organization for the purpose of receiving Medicaid or KCHIP covered services.

(41) "Evidence of identity" means:

(a) A current state driver's license or state identity document bearing the individual's picture;

(b) A Certificate of Degree of Indian Blood or other United States American Indian or Alaska Native tribal document; or

(c) For a child who is age sixteen (16) or younger:

1. A school identification card with a photograph;

2. A military dependent's identification card, if it contains a photograph;

3. A school record that shows the:

a. Date and place of birth; and

b. Parent or parents' name;

4. A clinic, doctor, or hospital record showing date of birth;

5. A daycare or nursery school record showing date and place of birth; or

6. An affidavit signed under penalty of perjury by a parent or guardian attesting to the child's identity.

(42) "Excess shelter allowance" means an amount equal to the difference between the community spouse's verified shelter expenses and the minimum shelter allowance.

(43) "Fair market value" means an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred based on:

(a) The gross tax assessed value of the property as stated by the local property valuation administrator; or

(b) An independent, licensed appraiser.

(44) "Family alternatives diversion payment" means a lump sum payment made to a Kentucky Transitional Assistance Program applicant:

(a) To meet short-term emergency needs; and

(b) Pursuant to 921 KAR 2:500.

~~(45) "Family-related case" or "family case" means a Medicaid-eligible, medically-needy group based on deprivation and within the medically-needy income level.~~

~~(46) "Federal financial participation" is defined in 42 C.F.R. 400.203.~~

~~(46) [(47)] "Fee-for-service" means a reimbursement model in which a health insurer reimburses a provider for each service provided to a recipient.~~

~~(47) [(48)] "First month of SSI payment" means the first month for which an SSI-related Medicaid recipient is determined to be eligible for SSI payments.~~

~~(48) [(49)] "Foster care" is defined by KRS 620.020(5).~~

~~(49) [(50)] "Gross income" means non-excluded income which would be used to determine eligibility prior to income disregards.~~

~~(50) [(51)] "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.~~

~~(51) [(52)] "Homestead" means property:~~

~~(a) In which an individual has an ownership interest; and~~

~~(b) Which an individual uses as the individual's principal place of residence.~~

~~(52) [(53)] "ICF IID" means intermediate care facility for individuals with an intellectual disability.~~

~~(53) [(54)] "Impairment related work expenses" or "IRWE" means an SSI program option in which the United States Social Security Administration deducts the cost of items or services an individual needs, due to an impairment, in order to work.~~

~~(54) [(55)] "Incapacity" means a condition of mind or body making a parent physically or mentally unable to provide the necessities of life for a child.~~

~~(55) [(56)] "Income" means money received from:~~

~~(a) Statutory benefits (for example, Social Security, Veterans Administration pension, black lung benefits, or railroad retirement benefits);~~

~~(b) A pension plan;~~

~~(c) Rental property;~~

~~(d) An investment; or~~

~~(e) Wages for labor or services.~~

~~(56) [(57)] "Individual development account" means an account containing funds for the purpose of continuing education, purchasing a first home, business capitalization, or other purposes allowed by federal regulations or clarifications which meets the criteria established in 921 KAR 2:016.~~

~~(57) [(58)] "Institutionalized" means:~~

~~(a) Residing in a nursing facility;~~

~~(b) Receiving hospice services; or~~

~~(c) Receiving 1915(c) home and community based services.~~

~~(58) [(59)] "Institutionalized individual" means an individual with respect to whom payment is based on a level of care provided in a nursing facility and who is:~~

~~(a) An inpatient in:~~

~~1. A nursing facility;~~

~~2. An intermediate care facility for individuals with an intellectual disability; or~~

~~3. A medical institution; [or]~~

~~(b) Receiving 1915(c) home and community based services; or~~
~~(c) Receiving hospice services.~~

~~(59) [(60)] "Institutionalized spouse" means an institutionalized individual who:~~

~~(a) 1. Is in a medical institution or nursing facility; or~~

~~2. Participates in a 1915(c) home and community based services waiver program;~~

~~(b) Has a spouse who is not an institutionalized individual; and~~

~~(c) Is likely to remain institutionalized for at least thirty (30) consecutive days while the community spouse remains out of a medical institution, nursing facility, or 1915(c) home and community based services waiver program.~~

~~(60) [(61)] "KCHIP" means the Kentucky Children's Health Insurance Program administered in accordance with 42 U.S.C. 1397aa to jj.~~

~~(61) [(62)] "Kentucky Transitional Assistance Program" or "K-TAP" means:~~

~~(a) Kentucky's version of TANF; and~~

~~(b) A money payment program for children who are deprived of parental support or care in accordance with 921 KAR 2:006.~~

~~(62) [(63)] "Kentucky Women's Cancer Screening Program" means the program administered by the Department for Public Health:~~

~~(a) Which provides breast and cervical cancer screening and diagnostic services to low-income, uninsured, or underinsured women; and~~

~~(b) Which uses:~~

~~1. State funds; and~~

~~2. Monies from the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program, including Title XV funds.~~

~~(63) [(64)] "Keogh plan" means a full-fledged pension plan for self-employed individuals in the United States of America.~~

~~(64) [(65)] "Long-term care partnership insurance" is defined by KRS 304.14-640(4).~~

~~(65) [(66)] "Long-term care partnership insurance policy" means a policy meeting the requirements established in KRS 304.14-642(2).~~

~~(66) [(67)] "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.~~

~~(67) [(68)] "Mandatory categorically needy eligibility groups" means:~~

~~(a) Transitional medical assistance;~~

~~(b) Extended Medicaid due to child or spousal support collections;~~

~~(c) Children receiving or approved for [with] Title IV-E adoption assistance, foster care, or guardianship care;~~

~~(d) Qualified pregnant women and children;~~

~~(e) Mandatory poverty level related pregnant women;~~

~~(f) Mandatory poverty level related infants;~~

~~(g) Mandatory poverty level related children aged one (1) to five (5) years;~~

~~(h) Mandatory poverty level related children aged six (6) to eighteen (18) years;~~

~~(i) Deemed newborns in accordance with 42 C.F.R. 435.117;~~

~~(j) Individuals receiving supplemental security income benefits;~~

~~(k) Aged, blind, and disabled individuals residing in Social Security Act 209(b) states;~~

~~(l) Individuals receiving mandatory state supplement payments;~~

~~(m) Individuals who are essential spouses;~~

~~(n) Institutionalized individuals continuously eligible for Medicaid since 1973;~~

~~(o) Blind or disabled individuals eligible for Medicaid in 1973;~~

~~(p) Individuals who lost eligibility for supplemental security income benefits or state supplemental payments due to an increase in old age, survivors, and disability insurance benefits in 1972;~~

(q) Individuals who would be eligible for supplemental security income benefits or state supplement payments but for old age, survivors, and disability insurance benefits cost-of-living adjustment increases since April 1977;

(r) Disabled widows and widowers ineligible for supplemental security income benefits due to an increase in old age, survivors, and disability insurance benefits;

(s) Disabled widows and widowers ineligible for supplemental security income benefits due to early receipt of social security benefits;

(t) Working disabled under Social Security Act 1619(b);

(u) Disabled adult children;

(v) Qualified Medicare beneficiaries;

(w) Qualified disabled and working individuals;

(x) Specified low income Medicare beneficiaries; or

(y) Qualifying individuals.

(68) [(69)] "Mandatory state supplement" is defined by 42 C.F.R. 435.4.

(69) [(70)] "Maternity care" means prenatal, delivery, and postpartum care and includes care related to complications from delivery.

(70) [(71)] "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 supplemental security income;

(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 20:020; and

(e) Meets the resource standards established in 907 KAR 20:025.

(71) [(72)] "Medical institution or nursing facility" means a hospital, nursing facility, or intermediate care facility for individuals with an intellectual disability.

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

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

(74) "Medically needy" is defined by 42 C.F.R. 435.4.

(75) "Medically-needy income level" or "MNIL" means the basic maintenance standard used in the determination of Medicaid eligibility for the medically needy.

(76) "Medicare Part A" means federal health insurance that covers:

(a) Inpatient hospital or skilled nursing facility services, including blood transfusions;

(b) Hospice services; and

(c) Home health services.

(77) "Medicare qualified individual group 1 (QI-1)" means an eligibility category, in which pursuant to 42 U.S.C. 1396a(a)(10)(E)(iv), an individual who would be a qualified Medicaid beneficiary but for the fact that the individual's income:

(a) Exceeds the income level established in accordance with 42 U.S.C. 1396d(p)(2); and

(b) Is at least 120 percent, but less than 135 percent, of the federal poverty level for a family of the size involved and who are not otherwise eligible for Medicaid under the state plan.

(78) "Minimum shelter allowance" means an amount that is thirty (30) percent of the standard maintenance amount.

(79) "Minor" means the couple's minor child who:

(a) Is under the age of twenty-one (21) years;

(b) Lives with a community spouse; and

(c) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(80) "Minor parent" means a parent under the age of twenty-one (21).

(81) "Minor teenage parent" means an individual who:

(a) Has not attained eighteen (18) years of age;

(b) Is not married; and

(c) Has a minor child in his or her care.

(82) "Modified adjusted gross income" or "MAGI" is defined by 42 U.S.C. 1396a(e)(14)(G).

(83) "Month of separation" means the month in which an individual ceases living in the same household of a Medicaid eligible family.

(84) "Monthly income allowance" means an amount:

(a) Deducted in the posteligibility calculation for maintenance needs of a community spouse or other family member; and

(b) Equal to the difference between a spouse's and other family member's income and the appropriate maintenance needs standards.

(85) "NF" means nursing facility.

(86) "Non-filer" means an individual who:

(a) Does not intend to file taxes for the benefit year;

(b) Is a child living with both parents who do not expect to jointly file a tax return;

(c) Expects to be claimed as a tax dependent by someone other than a spouse, parent, or stepparent; or

(d) Is a child under nineteen (19) years of age who is claimed as a tax dependent by a non-custodial parent.

(87) "Nonqualified alien" means a resident of the United States of America who does not meet the qualified alien requirements established in 907 KAR 20:005, Section 2.

(88) "Non-recurring lump sum income" means money received at one (1) time which is normally considered as income, including:

(a) Accumulated back payments from Social Security, unemployment insurance, or workers' compensation;

(b) Back pay from employment;

(c) Money received from an insurance settlement, gift, inheritance, or lottery winning;

(d) Proceeds from a bankruptcy proceeding; or

(e) Money withdrawn from an IRA by an individual prior to the individual reaching the age where no penalty is imposed for withdrawing the IRA, KEOGH plan, deferred compensation, tax deferred retirement plan, or other tax deferred asset.

(89) "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.

(90) "Official poverty income guidelines" means the poverty income guidelines which are:

(a) Updated annually in the Federal Register by the United States Department of Health and Human Services, under authority of 42 U.S.C. 9902(2); and

(b) The latest poverty guidelines available as of March 1 of the particular state fiscal year.

(91) "Old Age, Survivors, and Disability Insurance" or "OASDI" means the social insurance program:

(a) More commonly known as "Social Security"; and

(b) Into which participants make payroll contributions based on earnings.

(92) "Optional state supplement" is defined by 42 C.F.R. 435.4.

(93) "Other family member" means a relative of either member of a couple who is a:

(a) Minor or dependent child;

(b) Dependent parent; or

(c) Dependent sibling.

(94) "Other family member's maintenance standard" means an amount equal to one-third (1/3) of the difference between the income of the other family member and the standard maintenance

amount.

(95) "Other unearned income" means:

- (a) Miner's benefits;
- (b) A pension;
- (c) An oil lease;
- (d) Mineral rights;

(e) Trust income actually available other than from a Medicaid qualifying trust;

(f) Job Training Partnership Act income, including Eastern Kentucky Concentrated Employment Program income, paid to a specified relative or second parent;

(g) Income from income indemnity policies;

(h) Income from an IRA that is:

1. Not received as non-recurring lump sum income; and

2. Prorated over the period of time the income covers (for example monthly, quarterly, or annually);

(i) Any portion of military combat pay made available to a family Medicaid household if used to establish the household's eligibility for Medicaid benefits; or

(j) Other income determined by the department to be other unearned income.

(96) "Otherwise available income" means income to which the community spouse has access and control, including gross income that would be used to determine eligibility under Medicaid without benefit of disregards for federal, state, and local taxes; child support payments; or other court ordered obligation.

(97) "Patient status criteria" means the patient status criteria established in 907 KAR 1:022.

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

(99) "Plan to Achieve Self Support" or "PASS" means an SSI program option which enables a disabled individual receiving SSI benefits to:

(a) Identify a work goal;

(b) Identify training, items, or services needed to reach the work goal; and

(c) Set aside money for installment payments or a down payment for items needed to reach the work goal.

(100) "Poverty level guidelines" means the poverty income guidelines updated annually in the Federal Register by the United States Department of Health and Human Services, under authority of 42 U.S.C. 9902(2).

(101) "Presumptive eligibility" means Medicaid eligibility determined:

(a) By a provider authorized by 907 KAR 20:050 to make a presumptive eligibility determination; and

(b) For a pregnant woman who qualifies for presumptive eligibility pursuant to 907 KAR 20:050.

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

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

(104) "Qualified alien" means an alien who, at the time the alien applies for or receives Medicaid, meets the requirements established in 907 KAR 20:005, Section 5(12)(a)1b or c.

(105) "Qualified disabled and working individual" is defined by 42 U.S.C. 1396d(s).

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

(107) "Qualified non-citizen" is defined in 8 U.S.C. 1641(b) and (c).

(108) "Qualified provider" means a provider who:

(a) Is currently enrolled with the department;

(b) Has been trained and certified by the department to grant presumptive eligibility to pregnant women; and

(c) Provides services of the type described in 42 U.S.C. 1396d(a)(2)(A) or (B) or 42 U.S.C. 1396d(a)(9).

(109)[(108)] "Qualifying income trust" or "QIT" means an irrevocable trust established for the benefit of an identified individual in accordance with 42 U.S.C. 1396p(d)(4)(B).

(110)[(109)] "Real property" means land or an interest in land with an improvement, permanent fixture, mineral, or appurtenance considered to be a permanent part of the land, and a building with

an improvement or permanent fixture attached.

(111)[(110)] "Recipient" is defined in KRS 205.8451(9).

(112)[(111)] "Resource assessment" means the assessment, at the beginning of the first continuous period of institutionalization of the institutionalized spouse upon request by either spouse, of the joint resources of a couple if a member of the couple enters a medical institution or nursing facility or becomes a participant in a 1915(c) home and community based services waiver program.

(113)[(112)] "Resources" mean cash money and other personal property or real property that:

(a) An individual:

1. Owns; and

2. Has the right, authority, or power to convert to cash; and

(b) Is not legally restricted for support and maintenance.

(114)[(113)] "Retirement, Survivors, and Disability Insurance" or "RSDI" means an insurance benefit program:

(a) Managed by the United States Social Security Administration;

(b) Also known as Social Security Disability or Social Security Disability Insurance; and

(c) Which aims to provide monthly financial support to individuals who have lost income due to retirement, disability, or death of a family provider.

(115)[(114)] "Rural health clinic" is defined by 42 C.F.R. 405.2401(b).

(116)[(115)] "Satisfactory documentary evidence of citizenship or nationality" is defined by 42 U.S.C. 1396b(x)(3)(A).

(117)[(116)] "Significant financial duress" means a member of a couple has established to the satisfaction of a hearing officer that the community spouse needs income above the level permitted by the community spouse maintenance standard to provide for medical, remedial, or other support needs of the community spouse to permit the community spouse to remain in the community.

(118)[(117)] "Social Security" means a social insurance program administered by the United States Social Security Administration.

(119)[(118)] "Social Security number" means a number issued by the United States Social Security Administration to United States citizens, permanent residents, or temporary (working) residents pursuant to 42 U.S.C. 405(c)(2).

(120)[(119)] "Special income level" means the amount which is 300 percent of the SSI standard.

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

(122)[(121)] "Spend-down liability" means the amount of money in excess of the Medicaid income eligibility threshold to which incurred medical expenses are applied to result in an individual's income being below the income eligibility threshold.

(123)[(122)] "Spousal protected resource amount" means resources deducted from a couple's combined resources for the community spouse in an eligibility determination for the institutionalized spouse.

(124)[(123)] "Spousal share" means one-half (1/2) of the amount of a couple's combined countable resources, up to a maximum of \$60,000 to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g).

(125)[(124)] "Spouse" means a person legally married to another under state law.

(126)[(125)] "SSI benefit" is defined by 20 C.F.R. 416.2101.

(127)[(126)] "SSI essential person, spouse, or nonspouse" means an individual necessary to an SSI recipient to enable the SSI recipient to be self-supporting.

(128)[(127)] "SSI general exclusion" means the twenty (20) dollars disregard from income allowed by the Social Security Administration in an SSI determination.

(129)[(128)] "SSI program" means the United States supplemental security income program.

(130)[(129)] "SSI standard" means the amount designated by the Social Security Administration as the federal benefit rate.

(131)[(130)] "Standard maintenance amount" means one-twelfth (1/12) of the federal poverty income guideline for a family

unit of two (2) members, with revisions of the official income poverty guidelines applied for Medicaid provided during and after the second calendar quarter that begins after the date of publication of the revisions, multiplied by 150 percent.

(132)[(131)] "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.

(133)[(132)] "State-funded adoption assistance" is defined by KRS 199.555(2).

(134)[(133)] "State plan" is defined by 42 C.F.R. 400.203.

(135)[(134)] "State spousal resource standard" means the amount of a couple's combined countable resources determined necessary by the department for a community spouse to maintain himself or herself in the community.

(136)[(135)] "Support right" means the right of an institutionalized spouse to receive support from a community spouse under state law.

(137)[(136)] "Targeted low-income child" is defined by 42 C.F.R. 457.310(a).

(138)[(137)] "Tax filer" means an individual who:

(a) Expects to file income tax for the benefit year either:

1. Individually; or
2. As a married individual filing jointly; or

(b) Expects to be claimed as a dependent on another individual's taxes during the benefit year.

(139)[(138)] "Temporary Assistance for Needy Families" or "TANF" means a block grant program which:

(a) Succeeded AFDC; and

(b) Is designed to:

1. Assist needy families so that children can be cared for in their own homes;
2. Reduce the dependency of needy parents by promoting job preparation, work, and marriage;
3. Prevent out-of-wedlock pregnancies; and
4. Encourage the formation and maintenance of two-parent families.

(140)[(139)] "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.

(141)[(140)] "Title IV-E benefits" means benefits received via Social Security Act Title IV, Part 3.

(142)[(141)] "Tobacco Master Settlement Agreement" means an agreement entered into in November 1998 between certain tobacco companies and states' attorneys general of forty-six (46) states:

(a) Which settled states' lawsuits against the tobacco industry for recovery of tobacco-related health care costs;

(b) Which exempted the tobacco companies from private tort liability regarding harm caused by tobacco; and

(c) In which the tobacco companies agreed to make various annual payments to the states to compensate for some of the medical costs incurred in caring for individuals with smoking-related illnesses.

(143)[(142)] "Transferred resource factor" means an amount that is:

(a) Equal to the average:

1. Monthly cost of nursing facility services in the state at the time of application; and
2. Of private pay rates for semi private rooms of all Medicaid participating facilities; and

(b) Adjusted annually.

(144)[(143)] "Trust" means a legal instrument or agreement valid under Kentucky state law in which:

(a) A grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee or trustees for the benefit of the grantor or certain designated individuals or beneficiaries; and

(b) A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefit of the beneficiaries.

(145)[(144)] "Trusted source" means a source recognized by the federal government or department as a reliable source for

verifying an individual's information.

(146)[(145)] "Uncompensated value" means the difference between the:

(a) Fair market value at the time of transfer, less any outstanding loans, mortgages, or other encumbrances on the asset; and

(b) Amount received for the asset.

(147)[(146)] "Undue hardship" means that:

(a) Medicaid eligibility of an institutionalized spouse cannot be established on the basis of assigned support rights; and

(b) The spouse is subject to discharge from the medical institution, nursing facility, or 1915(c) home and community based services waiver program due to inability to pay.

(148)[(147)] "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.

(149) "Valid immigrant status" is defined in:

(a) 8 U.S.C. 1101(a)(15); or

(b) 8 U.S.C. 1101(a)(17).

(150)[(148)] "Veteran" is defined in 38 U.S.C. 101(2).

(151)[(149)] "Ward" is defined in KRS 387.510(15).

(152)[(150)] "Women, Infants and Children program" means a federally-funded health and nutrition program for women, infants, and children.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 p.m.

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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 the definitions for administrative regulations located in Chapter 20 of Title 907 of the Kentucky Administrative Regulations. Chapter 20 contains Medicaid eligibility and eligibility-related administrative regulations.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in Chapter 20 of Title 907 of the Kentucky Administrative Regulations. Chapter 20 contains Medicaid eligibility and eligibility-related administrative regulations.

(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 establishes the definitions for administrative regulations located in Chapter 20 of Title 907 of the Kentucky Administrative Regulations. Chapter 20 contains Medicaid eligibility and eligibility-related administrative regulations.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing establishes the definitions for administrative regulations located in Chapter 20 of Title 907 of the Kentucky Administrative Regulations. Chapter 20 contains Medicaid eligibility and eligibility-related administrative regulations.

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

(a) How the amendment will change this existing administrative regulation: This "amended after comments" administrative regulation inserts a definition of "medically needy" in response to public comments; inserts a definition of qualified non-citizen; inserts a definition of valid immigrant status; and clarifies other definitions in response to public comments.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to clarify terms used in 907 KAR Chapter 20. The amendment after comments is necessary to insert new definitions or clarify existing definitions.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment will conform to the content of the authorizing statutes by clarifying terms used in 907 KAR Chapter 20. The amendment after comments conforms to the content of the authorizing statutes by inserting new definitions or clarifying existing definitions.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation. The amendment will conform to the content of the authorizing statutes by clarifying terms used in 907 KAR Chapter 20. The amendment after comments will assist in the effective administration of the authorizing statutes by inserting new definitions or clarifying existing definitions.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients and individuals applying for Medicaid are affected by the administrative regulation. Currently, over 800,000 individuals in Kentucky received Medicaid.

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

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

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Individuals will benefit due to the clarity of Medicaid eligibility terms being defined in this administrative regulation.

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

(a) Initially: No cost is necessary to initially implement this administrative regulation.

(b) On a continuing basis: No continuing cost is necessary to implement this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

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

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions for Medicaid eligibility administrative regulations.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation.

2. State compliance standards. KRS 194A.030(2) states, "The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act."

3. Minimum or uniform standards contained in the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services and Department for Community Based 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? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this administrative regulation in the first year.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary in subsequent years to implement this administrative regulation.

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

Revenues (+/-): .

Expenditures (+/-):

Other explanation: No additional expenditures are necessary to implement this amendment.

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 20:005. Medicaid technical eligibility requirements not related to a modified adjusted gross income standard or former foster care individuals.

RELATES TO: KRS 205.520, 205.6481-205.6497, 341.360, 42 C.F.R. 435, 403, 45 C.F.R. 233.100, 8 U.S.C. 1101, 1153(a)(7), 1157, 1158, 1182(d)(5), 1231(b)(3), 1253(h), 1522, 1612, 1613, 1622, 1641, 38 U.S.C. 101, 107, 1101, 1301, 1304, 5303A, 42 U.S.C. 402, 416, 423, 1382c, 1383c, 1395i, 1396a

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(10), (r)(2), 1396b(f), 1396d(q)(2)(B), 1397aa

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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the technical eligibility requirements of the Medicaid program except for individuals whose Medicaid eligibility standard is a modified adjusted gross income or for former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Individuals to whom the technical eligibility requirements in this administrative

regulation apply include children in foster care; aged, blind, or disabled individuals; and individuals who receive supplemental security income benefits.

Section 1.[Definitions.—(1) "Cabinet" is defined by KRS 218A.010(3).

(2) "Child" means a person who:

(a) 1. a. Is under the age of eighteen (18); or

b. Is under age nineteen (19) if the person is:

(i) A full-time student in a secondary school or the equivalent level of vocational or technical training; and

(ii) Expected to complete the program before age nineteen (19);

2. Is not self-supporting;

3. Is not a member of the Armed Forces of the United States; and

4. If previously emancipated by marriage, has returned to the home of his parents, or to the home of another relative; or

(b) Has not attained nineteen (19) years of age as specified in 42 U.S.C. 1396a(l)(1).

(3) "Evidence of identity" means:

(a) A current state driver's license or state identity document bearing the individual's picture;

(b) A certificate of Indian Blood or other United States American Indian or Alaska Native tribal document; or

(c) For a child who is age sixteen (16) or younger:

1. A school identification card with a photograph;

2. A military dependent's identification card, if it contains a photograph;

3. A school record that shows the:

a. Date and place of birth; and

b. Parent or parents' name;

4. A clinic, doctor, or hospital record showing date of birth;

5. A daycare or nursery school record showing date and place of birth; or

6. An affidavit signed under penalty of perjury by a parent or guardian attesting to the child's identity.

(4) "Kentucky Transitional Assistance Program" or "K-TAP" means Kentucky's version of the federal block grant program of Temporary Assistance for Needy Families (TANF), a money payment program for children who are deprived of parental support or care due to:

(a) Death;

(b) Continued voluntary or involuntary absence;

(c) Physical or mental incapacity of one (1) parent or step-parent if two (2) parents are in the home; or

(d) Unemployment of one (1) parent if both parents are in the home.

(5) "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 supplemental security income;

(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.

(6) "Minor teenage parent" means an individual who:

(a) Has not attained eighteen (18) years of age;

(b) Is not married; and

(c) Has a minor child in his care.

(7) "Satisfactory documentary evidence of citizenship or nationality" means:

(a) A United States passport;

(b) A Certificate of Naturalization (DHS Form N-550 or N-570);

(c) A Certificate of United States Citizenship (DHS Form N-560 or N-561);

(d) One (1) of the following documents submitted with evidence of identity if a document identified in paragraphs (a) through (c) of this subsection is not available or cannot be obtained:

1. A United States birth certificate;

2. A Certification of Birth issued by the Department of State (Form DS-1350);

3. A Report of Birth Abroad of a Citizen of the United States (Form FS-240);

4. A Certification of Birth Abroad (FS-545);

5. A United States Citizen Identification Card (DHS Form I-197);

6. An American Indian Card (I-872);

7. A final adoption decree;

8. Evidence of civil service employment by the United States government before June 1976; or

9. An official military record of service showing a United States place of birth;

(e) One (1) of the following documents submitted with evidence of identity if a document identified in paragraphs (a) through (d) of this subsection is not available or cannot be obtained:

1. An extract of a United States hospital record of birth that:

a. Was established at the time of a person's birth;

b. Was created at least five (5) years before the initial application date; and

c. Indicates a United States place of birth; or

2. A life, health, or other insurance record that:

a. Shows a United States place of birth; and

b. Was created at least five (5) years before the initial application date; or

(f) One (1) of the following documents submitted with evidence of identity if a document identified in paragraphs (a) through (e) of this subsection is not available or cannot be obtained, the applicant alleges citizenship, and nothing exists to indicate the person is not a citizen:

1. Federal or state census record showing:

a. United States citizenship; or

b. A United States place of birth;

2. Institutional admission papers that:

a. Are from a nursing facility, skilled nursing facility, or other institution;

b. Were created at least five (5) years before the initial application date; and

c. Indicate a United States place of birth;

3. Medical record that:

a. Was created at least five (5) years before the initial application date, unless the application is for a child under age five (5); and

b. Indicates a United States place of birth unless the application is for a child under age five (5); or

4. Written affidavit by at least two (2) individuals:

a. Of whom one (1) is not related to the applicant;

b. Who have personal knowledge of the event establishing the applicant's claim of citizenship; and

c. Who provide proof of their own citizenship and identity.

(8) "Qualified alien" means an alien who, at the time the alien applies for or receives Medicaid, meets the requirements established in Section 5(12) of this administrative regulation.

(9) "Veteran" is defined in 38 U.S.C. 101(2).

Section 2.] The Categorically Needy. (1) An individual receiving Title IV-E benefits, SSI benefits, or an optional or a mandatory state supplement[Supplemental Security Income, or Optional or Mandatory State Supplementation] shall be eligible for Medicaid as a categorically-needy individual.

(2) The following classifications of [needy] persons shall be considered[included in the program as] categorically needy and [thus] eligible for Medicaid participation as categorically needy:

(a) A child in a foster family home[care] or private[nonprofit] child-caring facility[institution] dependent on a governmental or private agency;

(b) A child in a psychiatric hospital, psychiatric residential treatment facility, or intermediate care facility for individuals with an intellectual disability beginning with day thirty-one (31) of the

child's stay in the psychiatric hospital, psychiatric residential treatment facility, or intermediate care facility for individuals with an intellectual disability;

(c) ~~A pregnant woman;~~
 (d) ~~A child of unemployed parents;~~
 (e) ~~A child in a subsidized adoption dependent on a governmental agency;~~

(d) ~~(f)~~ ~~A child (but not his parents) who:~~

1. ~~Would have been financially eligible for Aid to Families with Dependent Children benefits using the AFDC methodologies in effect on July 16, 1996; and~~

2. ~~Meets the definition of Section 1(2) of this administrative regulation;~~

(g) ~~A qualified severely impaired individual as specified in 42 U.S.C. 1396a(a)(10)(A)(i)(II) and 1396d, [(t) to the extent the coverage is mandatory in this state];~~

(e) ~~(h)~~ ~~An individual who loses SSI benefit eligibility but would be eligible for SSI benefits except for entitlement to or an increase in his child's insurance benefits based on disability as specified in 42 U.S.C. 1383c;~~

(f) ~~(i)~~ ~~An individual specified in 42 U.S.C. 1383c who:~~

1. ~~Loses SSI benefits or state supplement[supplementation] payments as a result of receipt of benefits pursuant to 42 U.S.C. 402(e) or (f);~~

2. ~~Would be eligible for SSI benefits or state supplement payments[or-SSP] except for these benefits; and~~

3. ~~Is not entitled to Medicare Part A benefits[hospital insurance benefits under the Medicare program];~~

(g) ~~(j)~~ ~~A disabled widow, widower, or disabled surviving divorced spouse, who would be eligible for SSI benefits except for entitlement to an OASDI[old-age, survivors, or disability insurance (OASDI)] benefit resulting from a change in the definition of disability;~~

(h) ~~(k)~~ ~~A child who:~~

1. ~~Was receiving SSI benefits[supplemental security income] on August 22, 1996; and~~

2. ~~Except for the change in definition of childhood disability would continue to receive SSI benefits[supplemental security income]; or~~

(i) ~~(l)~~ ~~A person with hemophilia who would be eligible for SSI benefits[supplemental security income] except that the individual[he] received a settlement in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation".~~

(3) The classifications of ~~[needy]~~ persons listed in this subsection shall be ~~considered[included in the program as]~~ categorically-needy and ~~[thus]~~ eligible for Medicaid participation as limited by the provisions of this subsection.

(a) A family which correctly received Medicaid for three (3) of the last six (6) calendar months, and would have been terminated from receipt of AFDC using AFDC methodologies in effect on July 16, 1996 as a result of new or increased collection of child or spousal support, shall be eligible for extended Medicaid coverage for four (4) consecutive calendar months beginning with the first month the family would have been ineligible for AFDC.

(b) A family which would have been terminated from AFDC assistance using the AFDC methodologies in effect on July 16, 1996 because of increased earnings, hours of employment or loss of earnings disregards shall be eligible for up to ~~four (4)~~ ~~[twelve (12)]~~ months of extended Medicaid.

(c) ~~(e)~~ ~~A child born to a woman eligible for and receiving Medicaid shall be eligible for Medicaid as of the date of his birth if:~~

1. ~~The child:~~

a. ~~Has not reached his first birthday; and~~

b. ~~Resides in the household of the woman; and~~

2. ~~The woman remains, or would remain if pregnant, eligible for the assistance.~~

(d) 1. Except as provided in subparagraph 3 of this paragraph, an individual in an institution meeting appropriate patient status criteria who, if not institutionalized, would not be eligible for ~~SSI benefits[supplemental security income (SSI)]~~ or optional state supplement[supplementation] benefits due to income shall be eligible under a special income level which is set at 300 percent of the SSI benefit amount payable for an individual with no income.

2. Except as provided in subparagraph 3 of this paragraph, eligibility for a similar hospice participant or similar participant in a ~~1915(c) home and community based waiver program[in a waiver project of home and community based services]~~ for individuals with ~~an intellectual disability[the mentally retarded-]~~ or the aged, blind, or disabled shall be determined using the method established in subparagraph 1 of this subsection.

3. Eligibility of an ~~[institutionalized]~~ individual in an intermediate care facility for individuals with an intellectual disability (ICF IID) or supports for community living [(SCL)] for an individual with an intellectual disability or a developmental disability waiver meeting appropriate patient status criteria whose gross income exceeds 300 percent of the SSI benefit amount shall be determined by comparing the cost of the individual's care to the individual's income.

Section 2. Citizenship and Residency Requirements. (1) The citizenship requirements established in 42 C.F.R. 435.406 shall apply.

(2) Except as established in subsection (3) or (4) of this section, to satisfy the Medicaid:

(a) Citizenship requirement, an applicant or recipient shall be:

1. A citizen of the United States as verified through satisfactory documentary evidence of citizenship or nationality presented during initial application or if a current recipient, upon next redetermination of continued eligibility;

2. Except as provided in subsection (3) of this section, a qualified alien who entered the United States before August 22, 1996, and is:

a. Lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101;

b. Granted asylum pursuant to 8 U.S.C. 1158;

c. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

d. Paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) for a period of at least one (1) year;

e. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h), as in effect prior to April 1, 1997, or 8 U.S.C. 1231(b)(3);

f. Granted conditional entry pursuant to 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

g. An alien who is granted status as a Cuban and Haitian entrant pursuant to 8 U.S.C. 1522;

h. A battered alien pursuant to 8 U.S.C. 1641(c);

i. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

j. On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

k. The spouse or unmarried dependent child of an individual described in clause i. or j. of this subparagraph or the unremarried surviving spouse of an individual described in clause i. or j. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304; or

l. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

3. A qualified alien who entered the United States on or after August 22, 1996 and is:

a. Granted asylum pursuant to 8 U.S.C. 1158;

b. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

c. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h) as in effect prior to April 1, 1997 or 8 U.S.C. 1231(b)(3);

d. An alien who is granted status as a Cuban and Haitian entrant pursuant to 8 U.S.C. 1522;

e. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

f. On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C.

5303A(d);

g. The spouse or unmarried dependent child of an individual described in clause e. or f. of this subparagraph or the unmarried surviving spouse of an individual described in clause e. or f. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304;

h. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

i. An individual lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101 who has earned forty (40) quarters of Social Security coverage; and

(b) Residency requirements, the applicant or recipient shall be a resident of Kentucky who meets the conditions for determining state residency pursuant to 42 C.F.R. 435.403.

(3) A qualified or nonqualified alien shall be eligible for medical assistance as provided in this paragraph.

(a) The individual shall meet the income, resource, and categorical requirements of the Medicaid Program.

(b) The individual shall have, or have had within at least one (1) of the three (3) months prior to the month of application, an emergency medical condition:

1. Not related to an organ transplant procedure; and

2. Which shall be a medical condition, including severe pain, in which the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(c)1. Approval of eligibility shall be for a time limited period which includes, except as established in subparagraph 2 of this paragraph, the month in which the medical emergency began and the next following month.

2. The eligibility period shall be extended for an appropriate period of time upon presentation to the department of written documentation from the medical provider that the medical emergency will exist for a more extended period of time than is allowed for in the time limited eligibility period.

(d) The Medicaid benefits to which the individual is entitled shall be limited to the medical care and services, including limited follow-up, necessary for the treatment of the emergency medical condition of the individual.

(4)(a) The satisfactory documentary evidence of citizenship or nationality requirement in subsection (2)(a)1 of this section shall not apply to an individual who:

1. Is receiving SSI benefits;

2. Previously received SSI benefits but is no longer receiving them;

3. Is entitled to or enrolled in any part of Medicare;

4. Previously received Medicare benefits but is no longer receiving them;

5. Is receiving:

a. Disability insurance benefits under 42 U.S.C. 423; or

b. Monthly benefits under 42 U.S.C. 402 based on the individual's disability pursuant to 42 U.S.C. 223(d);

6. Is in foster care and who is assisted under Title IV-B of the Social Security Act; or

7. Receives foster care maintenance or adoption assistance payments under Title IV-E of the Social Security Act.

(b) The department's documentation requirements shall be in accordance with the requirements established in 42 U.S.C. 1396b(x).

(5) The department shall assist an applicant or recipient who is unable to secure satisfactory documentary evidence of citizenship or nationality in a timely manner because of incapacity of mind or body and lack of a representative to act on the applicant's or recipient's behalf.

(6) An individual shall be determined eligible for Medicaid for up to three (3) months prior to the month of application if all conditions of eligibility are met[(e) A woman during pregnancy, and as though pregnant through the end of the month containing the 60th day of a period beginning on the last day of pregnancy, or a child under six (6) years of age, as specified in 42 U.S.C. 1396a(l)(1), shall meet the income requirements for this eligibility group as specified in 907 KAR 1:640.

(f) If an eligible child is receiving covered inpatient services on a birthday which will make him ineligible due to age, the child shall remain eligible until the end of the stay for which the covered inpatient services are furnished if the child remains otherwise eligible except for age.

(g) A child who has attained six (6) years of age but has not attained nineteen (19) years of age as specified in 42 U.S.C. 1396a(l)(1) shall meet income requirements established in 907 KAR 1:640, Section 2(2)(c).

(h) If federal Medicaid matching funds are available to cover the costs of the program, an optional targeted low-income child as established in 907 KAR 4:020, Section 2(1) who has not attained the age of nineteen (19) years as specified in 42 U.S.C. 1396a(l)(1) shall meet the income requirements established in 907 KAR 1:640 Section 2(2)(f).

Section 3. The Medically Needy Who Qualify Via Spenddown. A medically needy individual[(1) An individual, including a child pursuant to Section 2(2)(f) of this administrative regulation or a pregnant woman] who has sufficient income to meet the individual's basic maintenance needs[,] may apply for Medicaid with need determined in accordance with the income and resource standards established in 907 KAR 20:020 through 907 KAR 20:045[1:640, through 907 KAR 1:665], if the individual meets:

(1)[(a)] The income and resource standards of the medically needy program established in 907 KAR 20:020[1:640] and 907 KAR 20:025[1:645]; and

(2)[(b)] The technical requirements of the appropriate categorically needy group identified in Section 1[2] of this administrative regulation.[(2) The medically needy eligible groups shall include:

(a) A pregnant woman during the course of her pregnancy;

(b) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance, and who shall continue to be eligible as though she were pregnant until the end of the month containing the 60th day of a period beginning on the last day of her pregnancy (i.e., the day on which her child is born or the pregnancy is otherwise terminated); and

(c) A Medicaid works individual.]

Section 4. Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, Specified Low-Income Medicare Beneficiaries, and Medicare Qualified Individuals Group 1 (QI-1)[(QI)]. (1) Coverage shall be extended to a qualified Medicare beneficiary as specified in 42 U.S.C. 1396a(a)(10)(E);

(a) Subject to the income limits established in 907 KAR 20:020;

(b) Subject to the resource limits established in 907 KAR 20:025; and

(c) For the scope of benefits specified for a QMB in 907 KAR 1:006.

(2) A QMB shall:

(a) Be eligible for or receive Medicare Part A and Part B benefits;

(b) Be determined to be eligible for QMB benefits effective for the month after the month in which the eligibility determination has been made; and

(c) Not be eligible for QMB benefits:

1. Retroactively; or

2. For the month in which the eligibility determination was made.

(3)[, subject to the income as shown in 907 KAR 1:640, and resource limitations shown in 907 KAR 1:645 and for the scope of benefits specified in 907 KAR 1:006 A qualified Medicare beneficiary shall:

(a) Be eligible for and receiving Medicare Part A benefits;

(b) Be determined eligible for benefits as a qualified Medicare beneficiary eligible individual effective for the month after the month in which the determination is made; and

(c) Not be eligible for benefits as a qualified Medicare beneficiary eligible individual:

1. Retroactively; or

2. For the month in which the determination was made.

(2) A qualified disabled and working individual[as defined in 42

U.S.C. 1396d(e)) shall be eligible under Medicaid for payment of the individual's[his] Medicare Part A premiums as established in 907 KAR 1:006.

(4)[(3)] A specified low-income Medicare beneficiary[as defined in 42 U.S.C. 1396a(a)(10)(E)(iii)] shall be eligible under Medicaid for payment of the Medicare Part B premiums.

(5)[(4)] A Medicare qualified individual group 1 (QI-1)[as established in 42 U.S.C. 1396a(a)(10)(E)(iv)] shall be eligible for payment of all of the Medicare Part B premium.

Section 5. Technical Eligibility Requirements. The technical eligibility factors[for a family or individual] included as categorically needy under Section 1[2] of this administrative regulation [or as medically needy under Section 3 of this administrative regulation] shall be as established in this section.

(1) **The following shall meet the requirements of a child in accordance with 907 KAR 20:001, Section 1(24):**

(a) A child in foster care;

(b) A child in[,] a private institution;

(c) A child in a[,] psychiatric hospital;

(d) A child in a[,] psychiatric residential treatment facility;[,] or

(e) A child in an intermediate care facility for individuals with an intellectual disability [shall meet the definition requirements of child as established in 907 KAR 20:001, Section 1(24)] [Section 1(2) of this administrative regulation].

(2) [Except as provided by Section 2 of this administrative regulation, a pregnant woman shall be eligible upon medical proof of pregnancy.

(3) At the time of application, unemployment relating to eligibility of both parents and children shall be determined using the following criteria:

(a) 1. Employment of less than 100 hours per month, except that the hours may exceed that standard for a particular month if:

a. The work is intermittent; and

b. The excess is of a temporary nature as evidenced by the fact that the individual:

(i) Was under the 100-hour standard for the prior two (2) months; and

(ii) Is expected to be under the standard during the next month;

2. Within twelve (12) months prior to application, a parent received unemployment compensation; or

3. A parent is receiving or has been found ineligible for unemployment compensation; and

(b) A parent shall not have refused suitable employment without good cause as determined in accordance with 45 C.F.R. 233.100(a)(3)(ii).

(4) Subsection (3)(a) of this section shall not apply if a change is made in a Medicaid case or if a case is recertified.

(5) An aged individual shall be at least sixty-five (65) years of age.

(3)[(6)] A blind individual shall meet the definition of blindness as contained in 42 U.S.C. 416 and 42 U.S.C. 1382c relating to Retirement, Survivors, and Disability Insurance or SSI benefits[retirement, survivors, and disability insurance (RSDI) or supplemental security income (SSI)].

(4)[(7)] A disabled individual shall meet the definition of permanent and total disability as established[contained] in 42 U.S.C. 423(d) and 42 U.S.C. 1382c(a)(3) relating to RSDI and SSI benefits.

(5)(a)[(8)] Using AFDC methodologies in effect on July 16, 1996, a family who loses Medicaid eligibility solely because of increased earnings or hours of employment of the caretaker relative or loss of earnings disregards may receive up to four (4)[~~twelve~~ (12)] months of extended medical assistance for family members included in the medical assistance unit prior to losing Medicaid eligibility.

(b)[The extended medical assistance shall be divided into two (2) transitional six (6) month benefit periods.] The family shall meet the eligibility and reporting requirements for the[each transitional] benefit period established in this subsection.

(c)[(a)] The[first transitional six (6) month] benefit period shall begin with the month the family would have become ineligible for AFDC using AFDC methodologies in effect on July 16, 1996.

1. To be eligible for this transitional benefit period, the family shall:

a. Have correctly received Medicaid assistance in three (3) of the six (6) months immediately preceding the month the family would have become ineligible for AFDC using AFDC methodologies in effect on July 16, 1996;

b. Have a dependent child living in the home; and

c. Report earnings and child care costs no later than the 21st day of the fourth month.

2. If the family no longer has a dependent child living in the home, medical assistance shall be terminated the last day of the month the family no longer includes a dependent child.

(6)[3. If the reporting requirements are not met, the Medicaid benefits shall be denied for the second transitional six (6) month benefit period.

(b) 1. To continue to receive Medicaid for the optional second transitional six (6) month benefit period, the family shall:

a. Have received medical assistance for the entire first transitional six (6) month period and met the reporting requirements;

b. Have a dependent child living in the home;

c. Have gross income minus child care cost equaling less than 185 percent of the federal poverty income level;

d. Report earnings and child care costs no later than the 21st day of the fourth month, the seventh month, and the tenth month; and

e. During the immediately preceding three (3) months, have a caretaker relative who shall have been:

(i) Employed; or

(ii) If unemployed in one (1) or more months, unemployed due to involuntary loss of employment, illness or other good cause established to the satisfaction of the Medicaid program in accordance with paragraph (c) of this subsection.

2. If a family no longer has a dependent child living in the home, Medicaid shall be terminated the last day of the month the family no longer includes a dependent child.

3. If the family's income exceeds the income standard or the family does not meet the reporting requirements, except for good cause established to the satisfaction of the Medicaid program in accordance with paragraph (c) of this subsection, the medical assistance shall be terminated the last day of the appropriate reporting month.

(c) Good cause shall exist under the following circumstances:

1. The specified relative was out-of-town for the reporting month;

2. An immediate family member living in the home was institutionalized or died during the reporting month;

3. The assistance group was the victim of a natural disaster including a flood, storm, earthquake or serious fire; or

4. The assistance group moved and reported the move timely, but the move resulted in a delay in receiving or failure to receive the transitional medical assistance report form.

(9) A parent, including a natural or adoptive parent, may be included for assistance in the case of a family with a child.

(a) If a parent is not included in the case, one (1) other caretaker relative may be included to the same extent he would have been eligible in the Aid to Families with Dependent Children program using the AFDC methodology in effect on July 16, 1996.

(b) A caretaker relative shall include:

1. Grandfather;

2. Grandmother;

3. Brother;

4. Sister;

5. Uncle;

6. Aunt;

7. Nephew;

8. Niece;

9. First cousin;

10. A relative of the half-blood;

11. A preceding generation denoted by a prefix of:

a. Grand;

b. Great; or

c. Great-great; or

12. A stepfather, stepmother, stepbrother, or stepsister.

(10)] An applicant who is deceased shall have eligibility determined in the same manner as if the applicant[he] were alive[.] to cover medical expenditures during the terminal illness.

(7)(a)(11) ~~Children of the same parent, i.e., a "common" parent, residing in the same household shall be included in the same case unless this acts to preclude eligibility of an otherwise eligible household member. If a family member is pregnant, the unborn child shall be considered as a family member for budgeting purposes.~~

(12) The citizenship and residency requirements established in this subsection shall be applicable.

(a) To be eligible for Medicaid, an applicant or recipient shall be:

1.a. A citizen of the United States as verified through satisfactory documentary evidence of citizenship or nationality presented during initial application or if a current recipient, upon next redetermination of continued eligibility. The cabinet:

(i) Shall exempt an applicant or recipient who currently receives Medicare or SSI or who no longer receives Medicare or SSI, but has received one (1) of them in the past, from providing further documentation of citizenship or nationality;

(ii) Shall assist an applicant or recipient who is unable to secure satisfactory documentary evidence of citizenship or nationality in a timely manner because of incapacity of mind or body and lack of a representative to act on the applicant's or recipient's behalf; and

(iii) May use a cross match with the cabinet's Office of Vital Statistics to document a birth record or use a cross match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals;

b. Except as provided in paragraph (b) of this subsection, a qualified alien who entered the United States before August 22, 1996 and is:

(i) Lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101;

(ii) Granted asylum pursuant to 8 U.S.C. 1158;

(iii) A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

(iv) Paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) for a period of at least one (1) year;

(v) An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h), as in effect prior to April 1, 1997, or 8 U.S.C. 1231(b)(3);

(vi) Granted conditional entry pursuant to 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

(vii) An alien who is granted status as a Cuban and Haitian entrant pursuant to 8 U.S.C. 1522;

(viii) A battered alien pursuant to 8 U.S.C. 1641(c);

(ix) A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

(x) On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

(xi) The spouse or unmarried dependent child of an individual described in subclause (ix) or (x) of this clause or the unmarried surviving spouse of an individual described in subclause (ix) or (x) of this clause if the marriage fulfills the requirements established in 38 U.S.C. 1304; or

(xii) An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

c. A qualified alien who entered the United States on or after August 22, 1996 and is:

(i) Granted asylum pursuant to 8 U.S.C. 1158;

(ii) A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

(iii) An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h) as in effect prior to April 1, 1997 or 8 U.S.C. 1231(b)(3);

(iv) An alien who is granted status as a Cuban and Haitian

entrant pursuant to 8 U.S.C. 1522;

(v) A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

(vi) On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

(vii) The spouse or unmarried dependent child of an individual described in subclause (v) or (vi) of this clause or the unmarried surviving spouse of an individual described in subclause (v) or (vi) of this clause if the marriage fulfills the requirements established in 38 U.S.C. 1304;

(viii) An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

(ix) An individual lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101 who has earned forty (40) quarters of Social Security coverage; and

2. A resident of Kentucky meeting the conditions for determining state residency under 42 C.F.R. 435.403.

(b) A qualified or nonqualified alien shall be eligible for medical assistance as provided in this paragraph.

1. The alien shall meet the income, resource and categorical requirements of the Medicaid Program.

2. The alien shall have, or have had within at least one (1) of the three (3) months prior to the month of application, an emergency medical condition not related to an organ transplant procedure, which shall be a medical condition, including severe pain, in which the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

3. Approval of eligibility shall be for a time limited period, with that period to include the month in which the medical emergency began and the next following month, with the added provision that the eligibility period shall be extended for an appropriate period of time upon presentation to the department of written documentation from the medical provider that the medical emergency will exist for a more extended period of time than is allowed for in the time limited eligibility period.

4. The Medicaid benefits to which the alien is entitled shall be limited to the medical care and services (including limited follow-up) necessary for the treatment of the emergency medical condition of the alien.

(13)] An individual shall be determined eligible for Medicaid for up to three (3) months prior to the month of application if all conditions of eligibility are met and the applicant is not enrolled in a managed care organization[partnership].

(b)[(a) Except as provided in paragraphs (b) and (c) of this subsection,]The effective date of Medicaid shall be the first day of the month of eligibility.

(8)(a)(b) For an individual eligible on the basis of desertion, a period of desertion shall have existed for thirty (30) days, and the effective date of eligibility shall not precede the first day of the month of application.

(c) For an individual eligible on the basis of utilizing his excess income for incurred medical expenses, the effective date of eligibility shall be the day the spend-down liability is met.

(14)] Benefits shall be denied to a family for a month in which a parent with whom the child is living is, on the last day of the month, participating in a strike, and the individual's needs shall not be considered in determining eligibility for Medicaid for the family if, on the last day of the month, the individual is participating in a strike.

(b) A strike shall include a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) or[and] any concerted slowdown or other concerted interruption of operations by employees.[(15) A caretaker relative (but not a child) removed from a family related Medicaid only case due to failure to meet a technical eligibility requirement shall not be eligible for Medicaid as a medically needy individual unless the individual is separately eligible for medical assistance without regard to eligibility as a member of the group from which the individual has been removed.

~~(16) A caretaker relative, but not a child, who is ineligible for K-TAP benefits for failure to comply with K-TAP work requirements shall not be eligible for medical assistance unless the individual is eligible as a pregnant woman.]~~

Section 6. Institutional Status. (1) An individual shall not be eligible for Medicaid if the individual is a:

(a)[(4)] Resident or inmate of a nonmedical public institution except as provided in Section 7 of this administrative regulation;

(b)[(2)] Patient in a state tuberculosis hospital unless he has reached age sixty-five (65);

(c)[(3)] Patient in a mental hospital or psychiatric facility unless the individual is:

1.[(a)] Under [age] twenty-one (21) years of age;

2.[(b)] Under age twenty-two (22) if the individual[he] was receiving inpatient services on his or her 21st birthday; or

3.[(e)] Sixty-five (65) years of age or over; or

(d)[(4)] Patient in a nursing facility classified by the Medicaid program as an institution for mental diseases, unless the individual has reached age sixty-five (65).

(2) In accordance with subsection (1)(c) of this section, if an individual is receiving services in a mental hospital or psychiatric facility at the time the individual reaches twenty-one (21) years of age and the services remain medically necessary for the individual, the individual shall remain eligible for the services until the individual reaches age twenty-two (22) years of age.

Section 7. Emergency Shelters or Incarceration Status. (1) An individual or family group who is in an emergency shelter for a temporary period of time shall be eligible for medical assistance, even though the shelter is considered a public institution, under the following conditions[certain conditions. These conditions shall be as follows]:

(a)[(1)] The individual or family group shall:

1.[(a)] Be a resident of an emergency shelter no more than six (6) months in any nine (9) month period; and

2.[(b)] Not be in the facility serving a sentence imposed by the court, or awaiting trial; and

(b)[(2)] Eligibility for Medicaid shall have existed immediately prior to admittance to the shelter[,] or it shall exist immediately after leaving the shelter.

(2) An inmate may be eligible for Medicaid after having been admitted to a medical institution and been an inpatient at the institution for at least twenty-four (24) consecutive hours.

Section 8. Application for Other Benefits. (1) As a condition of eligibility for Medicaid, an applicant or recipient shall apply for each annuity, pension, retirement, and disability benefit to which the applicant or recipient[he] is entitled, unless the applicant or recipient[he] can show good cause for not doing so.

(a) Good cause shall be considered to exist if other benefits have previously been denied with no change of circumstances[,] or the individual does not meet all eligibility conditions.

(b) Annuities, pensions, retirement, and disability benefits shall include:

1. Veterans' compensations and pensions;
2. Retirement and survivors disability insurance benefits;
3. Railroad retirement benefits;
4. Unemployment compensation; and
5. Individual retirement accounts.

(2) An applicant or recipient shall not be required to apply for federal benefits if:

(a) The federal law governing that benefit specifies that the benefit is optional; and

(b) The applicant or recipient believes that applying for the benefit would be to the applicant's or recipient's[his] disadvantage.

(3) An individual who would be eligible for SSI benefits[supplemental security income (SSI)] but has not made application shall not be eligible for Medicaid.

Section 9. Assignment of Rights to Medical Support. By accepting assistance for or on behalf of a child, a recipient shall be

deemed to have made an assignment to the cabinet[for Health and Family Services] of any medical support owed for the child not to exceed the amount of Medicaid payments made on behalf of the recipient.

Section 10. Third-party Liability as a Condition of Eligibility. (1)(a) Except as provided in subsection (3) of this section, an individual applying for or receiving Medicaid shall be required as a condition of eligibility to cooperate with the cabinet[for Health and Family Services] in identifying, and providing information to assist the cabinet in pursuing, any third party who may be liable to pay for care or services available under the Medicaid program unless the individual has good cause for refusing to cooperate.

(b) Good cause for failing to cooperate shall exist if cooperation:

1. Could result in physical or emotional harm of a serious nature to a child or custodial parent;
 2. Is not in a child's best interest because the child was conceived as a result of rape or incest; or
 3. May interfere with adoption considerations or proceedings.
- (2) A failure of the individual to cooperate without good cause shall result in ineligibility of the individual.

(3) A pregnant woman eligible under poverty level standards shall not be required to cooperate in establishing paternity or securing support for her unborn child.

Section 11. Provision of Social Security Numbers. (1) Except as provided in subsections (2) and (3) of this section, an applicant or recipient of Medicaid shall provide a Social Security number as a condition of eligibility.

(2) An individual shall not be denied eligibility or discontinued from eligibility due to a delay in receipt of a Social Security number from the United States Social Security Administration if appropriate application for the number has been made.

(3) An individual who refuses to obtain a Social Security number due to a well-established religious objection shall not be required to provide a Social Security number as a condition of eligibility.

Section 12. Applicability. [(1)] The provisions and requirements of this administrative regulation shall:

(1)[(a)] Apply to:

(a)[1.] Children in foster care;

(b)[2.] Aged, blind, or disabled individuals; and

(c)[3.] Individuals who receive supplemental security income benefits; and

(2)[(b)] Not apply to an individual[;]

1.] whose Medicaid eligibility is determined:

(a) Using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or

(b) Pursuant to 907 KAR 20:075[2. Between the ages of nineteen (19) and twenty-six (26) years who:

a. Formerly was in foster care; and

b. Aged out of foster care while receiving Medicaid coverage.

(2) An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level][If the parent or caretaker relative and the child, unless the child is a deemed eligible

~~newborn, refuses to cooperate with obtaining a Social Security number for the newborn child or other dependent child, the parent or caretaker relative shall be ineligible due to failure to meet technical requirements].~~

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

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REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes technical eligibility requirements for Kentucky's Medicaid program for children in foster care; aged, blind, or disabled individuals; and individuals who receive supplemental security income (SSI) benefits. The requirements in this administrative regulation do not apply to individuals for whom a modified adjusted gross income, or MAGI, is the Medicaid income eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid program eligibility requirements in accordance with federal law and regulation and as authorized by KRS 194A.030(2) which establishes the Department for Medicaid Services as the commonwealth's single state agency for administering the federal Social Security Act.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Medicaid program technical eligibility requirements in accordance with federal law and 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 assists in the effective administration of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Medicaid program technical eligibility requirements in accordance with federal law and 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: The amendment establishes that the technical eligibility requirements do not apply to individuals for whom a modified adjusted gross income (or MAGI) is the Medicaid eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The Affordable Care Act bars the application of certain existing technical eligibility requirements to these populations. The requirements for MAGI individuals are being established in a separate administrative regulation – 907 KAR 20:100 – and the requirements for former foster care individuals are being established in another separate administrative regulation – 907 KAR 20:075. The MAGI group and former foster care group were created by the Affordable Care Act. An optional eligibility group which DMS has added to the administrative regulation is hospital admissions for incarcerated individuals who are admitted to an inpatient hospital for at least twenty-four (24) hours (provided that the individual meets Medicaid eligibility criteria.) DMS anticipates that some pregnant women will qualify under this option. Additionally, the amendment eliminates the Medicaid requirement that in order to receive coverage under Medicaid, newborns must live with the mother and that the mother must remain eligible for Medicaid (or would remain eligible if still pregnant) and also clarifies that the technical eligibility requirements apply to children in foster, care; aged, blind, or

disabled individuals; and individuals who receive supplemental security income benefits. The amendment also reduces the Medicaid benefit period for individuals who qualified for benefits via an eligibility option for individuals who received Aid to Families with Dependent Children (AFDC) from twelve (12) months to four (4) months. DMS is reducing the period as it anticipates that such individuals will be able to qualify for Medicaid benefits under the revised Affordable Care Act eligibility rules on a longer-term basis or be eligible to receive highly subsidized assistant with health insurance premiums via the Health Benefits Exchange being established in Kentucky as authorized by the Affordable Care Act. Also, the citizenship requirements are revised. Also, the definitions are deleted from the administrative regulation as the Department for Medicaid Services (DMS) is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house Medicaid eligibility administrative regulations. The amendment also includes language and formatting revisions to comply with KRS Chapter 13A requirements. The amendment after comments clarifies that Medicaid coverage for a child in a facility begins on day thirty-one (31) of the child's stay; rewords the section which establishes to which eligibility group the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations; and contains other revisions to better clarify provisions.

(b) The necessity of the amendment to this administrative regulation: The amendments regarding the MAGI group and the former foster care group are necessary to comply with a federal mandate (Affordable Care Act.) The amendment regarding newborn eligibility is necessary to comply with the Children's Health Insurance Program Reauthorization Act of 2009 provision, regarding newborn eligibility, which was codified into 42 U.S.C. 1396a(e)(4) and to comply with the Affordable Care Act requirement regarding populations to which technical eligibility requirements apply. The citizenship requirement amendment is necessary to comply with changes in the federal requirements. The amendment which reduces the Medicaid benefit period for individuals who qualified for benefits via an eligibility option for individuals who received Aid to Families with Dependent Children (AFDC) from twelve (12) months to four (4) months is necessary as DMS anticipates that such individuals will be able to qualify for Medicaid benefits under the revised Affordable Care Act eligibility rules on a longer-term basis or be eligible to receive highly subsidized assistant with health insurance premiums via the Health Benefits Exchange being established in Kentucky as authorized by the Affordable Care Act. The amendment after comments is necessary to clarify provisions.

(c) How the amendment conforms to the content of the authorizing statutes: The MAGI-related amendment and former foster care individual-related amendment conform to the content of the authorizing statutes by complying with federal mandates. The newborn-related amendment conforms with 42 U.S.C. 1396a(e)(4) by eliminating the Medicaid requirement that, in order to receive coverage under Medicaid, newborns must live with the mother and that the mother must remain eligible for Medicaid (or would remain eligible if still pregnant.) The amendment after comments will conform to the content of the authorizing statutes by clarifying provisions.

(d) How the amendment will assist in the effective administration of the statutes: The MAGI-related amendment and former foster care individual-related amendment will assist in the effective administration of the authorizing statutes by complying with federal mandates. The newborn-related amendment conforms with 42 U.S.C. 1396a(e)(4) by eliminating the Medicaid requirement that, in order to receive coverage under Medicaid, newborns must live with the mother and that the mother must remain eligible for Medicaid (or would remain eligible if still pregnant.) The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying provisions.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals for whom a modified adjusted gross income is used as the income eligibility standard are affected

as they are exempt from the requirements established in this administrative regulation. The Department for Medicaid Services (DMS) projects that the number of individuals, beginning January 1, 2014, for whom a modified adjusted gross income will be the Medicaid eligibility income standard will be 678,000. Former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage are also affected as they are likewise exempt from the requirements. DMS projects that number could reach over 3,300 within twelve (12) months. Incarcerated individuals (most likely those that are pregnant) are potentially affected in that any such individual who is admitted to an inpatient hospital for at least twenty-four (24) hours would qualify for Medicaid coverage. Additionally, newborns are affected by gaining Medicaid eligibility due to not having to live with their mother in order to be Medicaid eligible.

(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. Individuals would need to apply for Medicaid coverage in order to gain Medicaid coverage.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment imposes no cost on the regulated entities or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals exempt from the requirements will benefit by being exempt from the requirements. Incarcerated individuals (most likely pregnant individuals) who are admitted to an inpatient hospital for at least twenty-four (24) hours and meet Medicaid eligibility criteria would benefit by receiving Medicaid coverage. Additionally, newborns who would have not been eligible for Medicaid coverage due to the prior policy would presumably be eligible as a result of the amendment to the policy.

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

(a) Initially: DMS projects no cost as a result of exempting the MAGI population and former foster care individuals from the requirements in this administrative regulation. Requirements for those individuals are being established in separate administrative regulations. Covering inpatient hospital care for qualifying incarcerated individuals (most likely pregnant women) will reduce state general fund expenditures as the Department of Corrections currently pays for this care, but estimating the expenditure reduction for this segment of the incarcerated population is indeterminable.

(b) On a continuing basis: The response provided in paragraph (a) regarding the initial cost also applies as a cost estimate 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 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 under the Affordable Care Act and 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 to implement the amendments.

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

(9) Tiering: Is tiering applied? Tiering is applied in that the technical eligibility requirements do not apply to populations who are exempted from the requirements pursuant to the Affordable Care Act.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

2. State compliance standards. KRS 205.520(3) states, "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. 42 U.S.C. 1396a(e)(4) eliminates the Medicaid requirement that, in order to receive coverage under Medicaid, newborns must live with the mother and that the mother must remain eligible for Medicaid (or would remain eligible if still pregnant.) 42 U.S.C. 1396a(e) exempts the application of certain existing technical eligibility requirements to individuals whose Medicaid eligibility standard is a modified adjusted gross income. 42 U.S.C. 1396a(a)(10)(A)(i)(IX) creates the new eligibility group comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment neither imposes stricter nor additional nor different responsibilities nor requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment 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 (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(10) and 42 U.S.C. 1396a(e)(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.

(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 anticipates no revenue being generated for the first year for state or local government due to the amendment to this 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 anticipates no revenue being generated for subsequent years for state or local government due to the amendment to this administrative regulation.

(c) How much will it cost to administer this program for the first year? DMS projects no cost as a result of exempting the MAGI population and former foster care individuals from the requirements in this administrative regulation. Requirements for those individuals are being established in separate administrative regulations. Covering inpatient hospital care for qualifying incarcerated individuals (most likely pregnant women) will reduce state general fund expenditures as the Department of Corrections currently pays for this care, but estimating the expenditure reduction for this segment of the incarcerated population is indeterminable.

(d) How much will it cost to administer this program for subsequent years? The response provided in paragraph (c) regarding the first year cost also applies as 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: No additional expenditures are necessary to implement this amendment.

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 20:010. Medicaid procedures for determining initial and continuing eligibility other than procedures related to a modified adjusted gross income eligibility standard or related to former foster care individuals.

RELATES TO: KRS 205.520, 42 C.F.R. 435.530, 435.531, 435.540, 435.541, 435.914, 435.916, 42 U.S.C. 416, 1382, 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

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 [for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes provisions relating to determining initial and continuing eligibility for assistance under the Medicaid Program except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals who aged out of foster care while receiving Medicaid coverage.

Section 1. [Definition. (1) "Department" means the Department for Medicaid Services or its designee.

(2) "First month of SSI payment" means the first month for which an SSI-related Medicaid recipient is determined to be eligible for SSI payments.

(3) "Partnership" means an entity that meets the criteria established in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver), Section 5, and, under contract with the department in accordance with KRS Chapter 45A, agrees to provide, or arrange for the provision of, health services to members on the basis of prepaid capitation payments.

Section 2. Eligibility Determination Process. (1)(a) Except as provided in subsection (3) or (5) of this section, eligibility shall be determined prospectively.

(b) To receive or continue to receive assistance, a household shall meet technical and financial eligibility criteria, for the appropriate month of coverage, pursuant to:

1. [Pursuant to] This section;[:]

2. [Pursuant to] Section 3 of this administrative regulation;[:]

and

3. As established in:

a. 907 KAR 20:005;

b. 907 KAR 20:020; and

c. 907 KAR 20:025 [the following administrative regulations for the appropriate month of coverage:

a. 907 KAR 1:011, Technical eligibility requirements;

b. 907 KAR 1:640, Income standards for Medicaid; and

c. 907 KAR 1:645, Resource standards for Medicaid].

(2) A decision regarding eligibility or ineligibility for Medicaid shall be supported by facts recorded in the case record.

(a) The applicant or recipient shall be the primary source of information and shall:

1. Furnish verification of financial and technical eligibility as required by 907 KAR 20:005, 907 KAR 20:020, and 907 KAR

20:025 [the following administrative regulations:

a. 907 KAR 1:011, Technical eligibility requirements;

b. 907 KAR 1:640, Income standards for Medicaid; and

c. 907 KAR 1:645, Resource standards for Medicaid]; and

2. Give written consent to those contacts necessary to verify or clarify a factor pertinent to the decision of eligibility.

(b)1. The department may schedule an appointment with an applicant or recipient to receive specified information as proof of eligibility.

2. Failure to appear for the scheduled appointment or to furnish the requested information shall be considered a failure to present adequate proof of eligibility if the applicant or recipient was informed in writing of the scheduled appointment and the required information.

(3) Retroactive eligibility for Medicaid not related to the receipt of SSI benefits shall be effective no earlier than the third month prior to the month of application if:

(a) A Medicaid service was received;

(b) Technical and financial eligibility requirements were met as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025 [the following administrative regulations:

1. 907 KAR 1:011, Technical eligibility requirements for Medicaid;

2. 907 KAR 1:640, Income standards for Medicaid; and

3. 907 KAR 1:645, Resource standards for Medicaid]; and

(c) [1-] The applicant is excluded from managed care organization participation in accordance with 907 KAR 17:010 [resides in a nonpartnership county; or

2. The applicant resides in a county served by a partnership and meets one (1) of the excluded categories as established in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver)].

(4) Eligibility for qualified Medicare beneficiary [(QMB)] coverage shall be effective the month after the month of case approval if technical and financial eligibility requirements were met as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025 [the following administrative regulations:

(a) 907 KAR 1:011, Technical eligibility requirements;

(b) 907 KAR 1:640, Income standards for Medicaid; and

(c) 907 KAR 1:645].

(5) [(a)] Retroactive eligibility for specified low-income Medicare beneficiary [(SLMB)] benefits, Medicare qualified individual group 1 (Q1-1) [individuals (Q1)] benefits, or qualified disabled and working individuals shall be effective no earlier than the third month prior to the month of application if the[an] individual meets technical and financial eligibility requirements as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025 [the following administrative regulations:

1. 907 KAR 1:011, Technical eligibility requirements for Medicaid;

2. 907 KAR 1:640, Income standards for Medicaid; and

3. 907 KAR 1:645, Resource standards for Medicaid.

(b) Retroactive eligibility for a qualified individual shall not include months of a prior year].

(6) An SSI-related recipient [age twenty-one (21) or older], in accordance with HCFA Program Issuance Transmittal Notice, Region IV, May 7, 1997, MCD-014-97, shall be eligible for Medicaid benefits effective the month prior to the first month of SSI payment if the individual [recipient]:

(a) Is eligible to be enrolled with a managed care organization in accordance with 907 KAR 17:010 [Resides in a partnership county]; and

(b) Meets Medicaid eligibility requirements for that month.

(7) An SSI-related recipient [age twenty-one (21) or older], in accordance with HCFA Program Issuance Transmittal Notice, Region IV, May 7, 1997, MCD-014-97, shall be retroactively eligible for Medicaid benefits effective no earlier than the third month prior to the first month of SSI payment if the individual [recipient]:

(a) Is excluded from managed care organization participation in accordance with 907 KAR 17:010 [(a)1. Resides in a nonpartnership county]; and

(b) [2-] Meets Medicaid eligibility requirements for these

months]; or

(b)1. ~~Resides in a partnership county; and~~

2. ~~Meets the requirements for one (1) of the excluded categories established in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver).~~

(8) ~~For an SSI recipient under age twenty-one (21), Medicaid coverage shall:~~

(a) ~~Automatically begin with the month prior to the first month of SSI payment; and~~

(b) ~~Be available for the three (3) preceding months if the recipient meets Medicaid eligibility requirements for those three months].~~

Section 2.3. Continuing Eligibility. (1) ~~The~~A recipient shall be responsible for reporting within ten (10) days a change in circumstances which may affect eligibility.

(2) ~~In addition,~~ Eligibility shall be redetermined:

(a) Every twelve (12) months; or

(b) If a report is received or information is obtained about a change in circumstances. ~~(2) Pursuant to the waiver granted by the Secretary, United States Department of Health and Human Services, and promulgated as 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver), a recipient shall have a one (1) time guarantee of six (6) months of eligibility regardless of a loss of technical eligibility for Medicaid during that six (6) month time period if the recipient:~~

(a) ~~Resides in a county included in a partnership;~~

(b) ~~Did not meet one (1) of the excluded categories established in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver);~~

(c) ~~Did not receive Medicaid in any of the twelve (12) months preceding participation in a partnership;~~

(d) ~~Participated in a partnership for less than six (6) months;~~

(e) ~~Continued to reside in a partnership region during the guaranteed six (6) month eligibility period; and~~

(f) ~~Is not:~~

1. ~~An incarcerated recipient;~~

2. ~~An alien who is eligible for emergency Medicaid; or~~

3. ~~A recipient requesting discontinuance of Medicaid.]~~

Section 3.4. Determination of Incapacity or Permanent and Total Disability. (1) Except as provided in subsections (2) and (3) of this section, a determination that a parent with whom the needy child lives is incapacitated, or that the individual requesting Medicaid due to disability is both permanently and totally disabled, shall be made by the medical review team following review of both medical and social reports.

(2) A parent shall be considered incapacitated without a determination from the medical review team if:

(a) The parent declares physical inability to work;

(b) The worker observes some physical or mental limitation; and

(c) The parent:

1. Is receiving SSI benefits~~[supplemental security income (SSI)]~~;

2. Is age sixty-five (65) years or over;

3. Has been determined to meet the definition of blindness or permanent and total disability as contained in 42 U.S.C. 1382 or 416 by either the Social Security Administration or the medical review team;

4. a. Has previously been determined to be incapacitated or both permanently and totally disabled by the medical review team, hearing officer, appeal board, or court of proper jurisdiction without a reexamination requested; and

b. There is no visible improvement in condition;

5. Is receiving Retirement, Survivors, and Disability Insurance ~~[(RSDI)]~~ benefits, federal black lung benefits, or railroad retirement benefits based on disability as evidenced by an award letter;

6. Is receiving Veterans ~~Affairs~~Administration (VA) benefits based on 100 percent disability, as verified by an award letter; or

7. a. Is currently hospitalized and a statement from the

attending physician indicates that incapacity will continue for at least thirty (30) days.

b. If application was made prior to the admission, the physician shall indicate if incapacity existed as of the application date.

(3) An individual shall be considered permanently and totally disabled without a determination from the medical review team if the individual:

(a) Receives RSDI or railroad retirement benefits based on disability;

(b) Received SSI benefits based on disability during a portion of the twelve (12) months preceding the application month and discontinuance was due to income or resources and[-] not to improvement in physical condition;

(c) Has been determined to meet the definition of blindness or both permanent and total disability as contained in 42 U.S.C. 416 or 1382 by the Social Security Administration; or

(d) 1. Has previously been determined to be permanently and totally disabled by the medical review team, hearing officer, appeal board, or court of proper jurisdiction without a reexamination requested; and

2. There is no visible improvement in condition.

(4)(a) A child who was receiving SSI~~[supplemental security income]~~ benefits on August 22, 1996 and who, but for the change in definition of childhood disability established by 42 U.S.C. 1396a(a)(10) would continue to receive SSI benefits, shall continue to meet the Medicaid definition of disability.

(b) If a redetermination is necessary, and in accordance with 921 KAR 5:470, the definition of childhood disability effective on August 22, 1996 shall be used.

Section 4.5. Disqualification. An adult individual shall be disqualified from receiving Medicaid for a specified period of time if the department or a court determines the individual has committed an intentional program violation in accordance with 907 KAR 1:675, Program integrity.

Section 5. Applicability. ~~[(4)]~~ The provisions and requirements of this administrative regulation shall not apply to an individual[:

(a)] whose Medicaid eligibility is determined:

(1) Using the modified adjusted gross income as the income standard pursuant to 907 KAR 20:100; or

(2) Pursuant to 907 KAR 20:075(b) Between the ages of nineteen (19) and twenty-six (26) years who:

1. Formerly was in foster care; and

2. Aged out of foster care while receiving Medicaid coverage;

(2) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level].

Section 6. Incorporation by Reference. (1) "HCFA Program Issuance Transmittal Notice Region IV", May 7, 1997, MCD-014-97, is incorporated by reference.

(2) This material may be:

(a) 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

(b) Viewed at <http://www.chfs.ky.gov/dms/incorporated.htm>.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 p.m.

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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 establishes that the eligibility determination procedures do not apply to individuals for whom a modified adjusted gross income (or MAGI) is the income eligibility standard or to former foster care individuals who aged out of foster care while receiving Medicaid coverage; removes definitions from the administrative regulation as those are now being established in a definitions administrative regulation for all administrative regulations within the new chapter – Chapter 20 – which will house Medicaid eligibility administrative regulations; and contains language and formatting revisions to comply with KRS Chapter 13A as this administrative regulation has not been amended since 1993. Individuals for whom a MAGI is the Medicaid income eligibility standard are children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment after comments rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations.

(b) The necessity of the amendment to this administrative regulation: The amendment exempting MAGI individuals and former foster care individuals from the requirement are necessary to comply with Affordable Care Act mandates. Eliminating the definitions from the administrative regulation is necessary as the Department for Medicaid Services is creating a definitions administrative regulation (907 KAR 20:001) for Chapter 20; and other amendments are necessary to ensure compliance with KRS Chapter 13A language and formatting requirements.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with Affordable Care Act mandates, by clarifying policy, and by 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 statutes by complying with Affordable Care Act mandates, by clarifying policy, and by 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: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) 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): No cost is imposed by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Individuals who are exempted from the requirements will benefit from not being subject to the requirements for Medicaid eligibility purposes.

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

(a) Initially: DMS anticipates no cost as a result of exempting the MAGI individuals or former foster care individuals from the requirements in this administrative regulation.

(b) On a continuing basis: The answer provided in paragraph (a) also applies here

(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 is only applied in that the provisions do not apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals as the Affordable Care Act prohibits this.

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 the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 435.906 and this administrative regulation authorize the action taken by this administrative regulation.

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

the first full year the administrative regulation is 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the income standards established in this administrative regulation nor from exempting former foster care individuals from the standards.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the MAGI individuals from the income standards established in this administrative regulation nor from exempting the former foster care individuals from the income standards.

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 U.S.C. 1396a(e)(14) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

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."

3. Minimum or uniform standards contained in the federal mandate. Effective January 1, 2014, each state's Medicaid program is required – except for certain designated populations - to determine Medicaid eligibility by using the modified adjusted gross income and is prohibited from using any type of expense, income disregard, or any asset or resource test. The populations exempted from the new requirements (and to whom the old requirements continue to apply) include aged individuals [individuals over sixty-five (65) years of age or who receive Social Security Disability Insurance; individuals eligible for Medicaid as a result of being a child in foster care; individuals who are blind or disabled; individuals who are eligible for Medicaid via another program; individuals enrolled in a Medicare savings program; and medically needy individuals. 42 U.S.C. 1396a(a)(10)(A)(i)(IX) creates the new eligibility group comprised of former foster care individuals and bars the application of certain existing Medicaid eligibility requirements to this population.

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 Policy and Operations

(Amended After Comments)

907 KAR 20:015. Medicaid right to apply and reapply for individuals whose Medicaid eligibility is not based on a modified adjusted gross income eligibility standard or who are not former foster care individuals.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 116.048, 194A.030(2), 194A.050(1), 205.502(3), 42 C.F.R. 435.906, 435.907, 435.909, 435.911, 435.912, 42 U.S.C. 1396a, b, d, w-3, 1973gg-10, [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) empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds [for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the [sets forth] provisions relating to the procedure by which an application for Medicaid coverage is filed, except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or for former foster care individuals between the ages of nineteen (19) and twenty-six (26) years who aged out of foster care while receiving Medicaid coverage. KRS 116.048 designates the cabinet to have responsibility for the administration of public assistance programs as a voter registration agency in accordance with 42 U.S.C. 1973gg-10. [Therefore,] This administrative regulation establishes the provisions and procedures [sets forth policy and procedure] necessary to provide an eligible Medicaid recipient the opportunity to register, or to decline from registering, to vote.

Section 1. Right to Apply or Reapply. (1) Each individual wishing to do so shall have the opportunity to apply or reapply for Medicaid through the Department for Community Based Services [Social Insurance (DSI)].

(2) [An individual eligible for TANF, mandatory state supplements, optional state supplements, or SSI benefits] [Aid to Families with Dependent Children (AFDC), State Supplemental or Supplemental Security Income (SSI)] [through the Social Security Administration shall be eligible for Medicaid without a separate application.

(3) (a) An individual applying on the basis of age, blindness, or disability shall not be eligible as a medically needy individual, under 907 KAR 20:005 [907 KAR 1:011], if the individual's [his] income and resources are within SSI limits.

(b) Denial of assistance by the Social Security Administration for SSI for technical reasons shall also be considered a denial for Medicaid benefits.

Section 2. Application Process. (1) An application shall be considered to have been made:

(a) 1. When the individual or individual's authorized [his] representative has signed, under penalty of perjury, the application [form] prescribed by the Department for Community Based Services [DSI] or the Social Security Administration, for SSI benefits; [and]

2. The application has been received [at the appropriate office]; or;

(2) ~~An application shall also be considered to be made~~ Based on the date of contact with the Department for Community Based Services[DSI] or the Social Security Administration for SSI benefits, by a person with a physical or mental impairment who needs special accommodation due to ~~the~~[his] impairment.

(3) If ~~an~~[the] applicant is unable to come to the office to apply, the applicant:

~~(a) Shall be advised that the applicant may apply via telephone; or~~

~~(b)~~[he] May designate an authorized representative to apply for the applicant[him] or request a home visit to complete the application process.

(4) ~~An~~[The] applicant may be:

(a) Assisted by an individual of the applicant's[his] choice in the application process; and

(b) ~~may be~~ Accompanied by this individual in all contacts with the agency.

(5) Deaf and hard of hearing services shall be provided in accordance with 920 KAR 1:070[900-KAR 1:070].

(6) Interpreter services shall be provided for persons who do not speak English, utilizing procedures and forms specified by 920 KAR 1:070[900-KAR 1:070].

Section 3. Who May Sign an Application. (1) An application for Medicaid shall be signed by the individual requesting assistance, the relative with whom the child lives ~~if the applicant is a child, or an authorized representative,~~ or an interested party acting on behalf of the applicant.

(2) An application for Medicaid for ~~a child~~[children] in foster care or for a private child caring ~~facility~~[institution][institutions] shall be signed by the:

(a) Representative of the agency to which the child is committed; or

(b) ~~Representative of the facility~~[the][Institution] in which the child is placed.

Section 4. ~~Where Applications are Filed and Processed.~~ (1) ~~An~~[The] application:

~~(a) 1. May be filed at any Department for Community Based Services~~[DSI][office]; and

~~2. Shall be processed in the county of residence except that any application for SSI benefits and Medicaid shall be filed in the service area office of the Social Security Administration.~~

~~(2) If an individual is applying for nursing facility or psychiatric facility services, the Department for Community Based Services~~[DSI][office in the county where the facility is located shall take and process the application.

~~(3) If an individual is applying in a county other than the county of residence and is hospitalized, the Department for Community Based Services~~[DSI][office in the county of:

~~(a) Hospitalization shall take the application and transfer the pending application to the county of residence; and~~

~~(b)~~[, and the DSI office in the county of][Residence shall process the application using the original application date.

~~(4)(a) If an individual is applying in a county other than the county of residence and is not hospitalized, the Department for Community Based Services~~[DSI][office in the receiving county shall:

~~1. Partially complete the application;~~

~~2.~~[,][Transfer the application to the county of residence on the same day the application is taken; and

~~3.~~[, and][Explain to the applicant that the application shall be processed in the county of residence.

~~(b) The Department for Community Based Services~~[DSI][office in the county of residence shall:

~~1. Schedule a face-to-face interview; and~~

~~2. Process the application using the original application date.~~

~~(5)(a) If a Kentucky resident is temporarily out of state, a letter from the applicant, an interested party, or an out-of-state agency shall be accepted as the initiation of the application process when:~~

~~1. An emergency arises from accident or sudden illness;~~
~~2.~~[,][Care and services are needed immediately;][, and
~~3. The individual's health would be endangered if the individual][he][undertook to return to the state.~~

~~(b) Upon notification of the emergency, the official application form shall be forwarded to the initiating party.~~

Section 5. Action on Applications. (1)(a) A decision shall be made on each Medicaid application within forty-five (45) days, except[that] for an application[applications] requiring a disability determination.

(b) An application requiring a disability determination shall be made within[, sixty (60) days][shall be allowed].

(2) An exception to the timeframes referenced in subsection (1) of this section shall be made if the[Time frame exceptions]:

(a)[If the] Applicant is cooperating but is unable to obtain necessary verification for an eligibility decision to be made; or

(b)[If the] Delay is beyond the control of staff (such as failure or delay on the part of the applicant or examining physician or because of some administrative or other emergency that could not be controlled by staff).

(3) ~~A~~[The] case record shall document the cause for the[time standard] delay.

(4) Failure to process an application within the[above] time frames referenced in this section[frame] shall not be used as the basis for denial.

Section 5.~~6.~~ Voter Registration. (1) An applicant or recipient ~~[meeting all of the following criteria]~~ shall be provided the opportunity at the local Department for Community Based Services[Social Insurance] office to complete an application to register to vote or update ~~the applicant's or recipient's~~[his] current voter registration ~~if the applicant or recipient is:~~

(a)[Be] Age eighteen (18) or over;

(b)[Be] Present in the office at the time of the interview or ~~when~~[if] a change of address is reported; and

(c) Not[be] registered to vote or not registered to vote at ~~the applicant's or recipient's~~[his] current address.

(2) The following individuals shall not be permitted to register to vote by the process established in this administrative regulation:

(a) An individual not included in the Medicaid application;

(b) A Medicaid payee only;

(c) An authorized representative of a Medicaid recipient; or

(d) An individual acting as a responsible party.

(3) An individual providing voter registration services who seeks to unlawfully influence an applicant's political preference or party registration as prohibited by KRS 116.048(4) ~~may~~[could] be fined or imprisoned, not to exceed five (5) years, or both.

(4) Forms and information utilized in the voter registration process shall:

(a) Remain confidential; and

(b) ~~Be~~ used only for voter registration purposes.

(5) Only Board of Elections officials may view forms and information utilized directly in the voter registration process.

(6)(a) Completion of the voter registration form is ~~only~~ an application to apply to register to vote.

(b) The State Board of Elections shall:

~~1. Approve or deny the application to register to vote; and~~

~~b. Send a confirmation or denial notice to the applicant.~~

Section 6.~~7.~~ Applicability. ~~(1)~~ The provisions and requirements of this administrative regulation shall:

~~(1)(a)~~ Apply to:

~~(a)~~[,] Children in foster care;

~~(b)~~[2.] Aged, blind, or disabled individuals; and

~~(c)~~[3.] Individuals who receive supplemental security income benefits; and

~~(2)(b)~~ Not apply to individuals[:

~~1.] whose Medicaid eligibility is determined:~~

~~(a) Using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or~~

~~(b) Pursuant to 907 KAR 20:075~~[2. Between the ages of nineteen (19) and twenty-six (26) years who formerly were in

foster care and were receiving Medicaid benefits at the time that they aged out of foster care.

(2) An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level.]

(Materials Incorporated by Reference. (1) Forms necessary for application for benefits under the Medicaid Program are incorporated effective April 1, 1995. These forms include the PA-1, revised October 1992; PA-1A, revised March 1991; PA-1C, revised October 1991; PA-1P, revised April 1992; PA-1UP, revised May 1991; and the KIM-100, revised March 1994.

(2) These forms may be reviewed at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621. Office hours are 8 a.m. to 4:30 p.m. Copies may be obtained upon payment of an appropriate fee which shall not exceed approximate cost].

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes Medicaid program provisions regarding applying for Medicaid benefits except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid program provisions regarding applying for Medicaid benefits except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard.

(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 provisions regarding applying for Medicaid benefits except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard.

(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 provisions regarding applying for Medicaid benefits except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard.

(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 agency (Department for Community Based Services); establishes that the provisions regarding applying for Medicaid benefits do not apply to

individuals for whom a modified adjusted gross income is the Medicaid income eligibility standard or to individuals between the ages of nineteen (19) and twenty-six (26) who formerly were in foster care but aged out of foster care while receiving Medicaid benefits at the time; deletes the definitions; deletes the incorporated material; and contains language and formatting revisions to comply with KRS Chapter 13A requirements. Individuals for whom a MAGI is the Medicaid income eligibility standard are children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment after comments eliminates some provisions which no longer apply; clarifies that individuals may apply for benefits via telephone; and rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations.

(b) The necessity of the amendment to this administrative regulation: The amendment replacing the agency title Department of Social Insurance with Department for Community Based Services is necessary to correct an obsolete reference; the amendments that establish that the provisions do not apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or to former foster care individuals are necessary to comply with an Affordable Care Act mandate; removing the definitions is necessary as the Department for Medicaid Services (DMS) is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house Medicaid eligibility administrative regulations; deleting the incorporated material is necessary as DMS does not utilize the incorporated material; and language and formatting revisions are necessary to comply with KRS Chapter 13A standards. The amendment after comments is necessary to eliminate obsolete provisions.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with a federal mandate and by complying KRS Chapter 13A standards. The amendment after comments conforms to the content of the authorizing statutes by eliminating obsolete provisions.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by complying with a federal mandate and by complying KRS Chapter 13A standards. The amendment after comments will assist in the effective administration of the authorizing statutes by eliminating obsolete provisions.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) 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): No cost is imposed by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Individuals who are exempted from the requirements will benefit from not being subject to the requirements for Medicaid eligibility purposes.

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

(a) Initially: DMS anticipates no cost as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the Medicaid application provisions of this administrative regulation as some related requirements and provisions (established in another administrative regulation) will apply to this population. Those requirements are being established in a new administrative regulation – 907 KAR 20:100, Modified adjusted gross income (MAGI) Medicaid eligibility standards. DMS projects a cost of \$ as a result of exempting former foster care individuals from the requirements in this administrative regulation; however, the Department for Community Based Services (DCBS) has been purchasing health insurance for 700 of those individuals at an annual cost of \$1 million. Covering those individuals through the Medicaid program, as mandated by federal law, will procure federal matching funds at a seventy (70) percent match rate for those individuals' health care.

(b) On a continuing basis: The answer provided in paragraph (a) also applies here.

(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 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: Neither an increase in fees nor funding is necessary to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is only applied in that the provisions do not apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals as the Affordable Care Act prohibits this.

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 the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 435.906 and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross

income is the Medicaid eligibility standard from the requirements in this administrative regulation nor from exempting former foster care individuals from the requirements.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the MAGI individuals from the requirements in this administrative regulation nor from exempting the former foster care individuals from the requirements.

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. 435.906, 42 C.F.R. 435.908, Section 1413 of the Affordable Care Act, 42 U.S.C. 1396w-3(b)(3), and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

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."

3. Minimum or uniform standards contained in the federal mandate. 42 C.F.R. 435.906 mandates that a Medicaid program must "afford an individual wishing to do so the opportunity to apply for Medicaid without delay." 42 C.F.R. 435.908 requires a Medicaid program to "allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility." 42 U.S.C. 1396w-3 requires a Medicaid program to enable individuals who are eligible to apply for Medicaid or a health insurance premium subsidy through a health benefit exchange to be able to apply through the Internet. Section 1413 of the Affordable Care Act and a bulletin issued by the Center for Medicaid and CHIP Services (CMCS) within the Centers for Medicare and Medicaid Services (CMS), dated April 30, 2013 regarding the application process for individuals applying for health insurance through the Health Insurance Marketplace or Affordable Insurance Exchange (labeled the Health Benefit Exchange in Kentucky) references mandate that individuals must be able to file an application online, by mail, over the telephone or in person. Only Medicaid individuals whose Medicaid eligibility income standard is a modified gross adjusted income can ultimately complete the application process in any of these ways. 42 U.S.C. 1396w-3(b)(3) addresses this requirement as follows: "The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1413 of the Patient Protection and Affordable Care Act (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP)." 4242 U.S.C. 1396a(a)(10)(A)(i)(IX) creates the new eligibility group comprised of former foster care individuals and bars the application of certain existing Medicaid eligibility requirements to this population.

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 Policy and Operations
(Amended After Comments)

907 KAR 20:020. Income standards for Medicaid other than Modified Adjusted Gross Income (MAGI) standards or for former foster care individuals.

RELATES TO: KRS 205.520, 38 U.S.C. 5503, 42 U.S.C. 1382a, 1396jj(b), 1397aa, 9902(2)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 435, 42 U.S.C. 1396a, 1396b, 1396d, 1397aa

NECESSITY, FUNCTION, AND CONFORMITY: [EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program in accordance with 42 U.S.C. 1396 through 1396v. 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 for the provisions of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the income standards by which Medicaid eligibility is determined, except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals who aged out of foster care while receiving Medicaid coverage.

Section 1. [Definitions. (1) "ABD" means an individual who is aged, blind, or disabled.

(2) "AFDC" means the Aid to Families with Dependent Children Program as it existed on July 16, 1996.

(3) "Child" means a person who:

(a) 1. a. Is under the age of eighteen (18); or

b. Is under the age of nineteen (19) if the person is:

(i) In high school or the same level of vocational or training school; and

(ii) Expected to graduate before or during the month of his 19th birthday;

2. Is not self-supporting;

3. Is not a member of the Armed Forces of the United States; and

4. If previously emancipated by marriage, has returned to the home of his parents or to the home of another relative; or

(b) Has not attained nineteen (19) years of age as specified in 42 U.S.C. 1396a(l)(1).

(4) "Family alternatives diversion payment" means a lump sum payment made to a K-TAP applicant to meet short-term emergency needs.

(5) "Incapacity" means a condition of mind or body making a parent physically or mentally unable to provide the necessities of life for a child.

(6) "Income" means money received from statutory benefits (including Social Security, Veteran's Administration pension, black lung benefits, or railroad retirement benefits), pension plans, rental property, investments, or wages for labor or services.

(7) "Lump sum income" means money received at one (1) time which is normally considered as income, including accumulated back payments from Social Security, unemployment insurance, or workman's compensation; back pay from employment; money received from an insurance settlement, gift, inheritance, or lottery winning; proceeds from a bankruptcy proceeding; or money withdrawn from an IRA, KEOGH plan, deferred compensation, tax

deferred retirement plan, or other tax deferred asset.

(8) "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 supplemental security income;

(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 this administrative regulation; and

(e) Meets the resource standards established in 907 KAR 1:645.

(9) "Minor parent" means a parent under the age of twenty-one (21).

(10) "Official poverty income guidelines" means the poverty income guidelines which are:

(a) Updated annually in the Federal Register by the United States Department of Health and Human Services, under authority of 42 U.S.C. 9902(2); and

(b) The latest poverty guidelines available as of March 1 of the particular state fiscal year.

(11) "SSI" means Supplemental Security Income Program.

—Section 2.] Income Limitations. (1)(a) [For the medically needy as described in 907 KAR 1:011,] Income shall be determined by comparing adjusted income as required by Section 2[3] of this administrative regulation, of the applicant, applicant and spouse, or applicant, spouse, and minor dependent children with the following scale of income protected for basic maintenance:

Size of Family	Annual	Monthly
1	\$2,600	\$217
2	3,200	267
3	3,700	308
4	4,600	383
5	5,400	450
6	6,100	508
7	6,800	567

(b) For each additional family member, \$720 annually or sixty (60) dollars monthly shall be added to the scale.

(2)[~~The following special factor~~][factors][~~shall apply~~][be applicable.] For a pregnant woman or child eligible pursuant to 42 U.S.C. 1396a(e)[:] [(a) A pregnant woman or a child under age one (1) shall have family income not exceeding 185 percent of the official poverty income guidelines;

(b) A child age one (1) or over but under age six (6) shall have family income not exceeding 133 percent of the official poverty income guidelines;

(c) A child born after September 30, 1983, who has attained six (6) years of age but has not attained nineteen (19) years of age shall have family income not exceeding 100 percent of the official poverty income guidelines;

(d) A pregnant woman or child who would be eligible under provisions of 42 U.S.C. 1396a(l) or 1397jj(b) except for income in excess of the allowable standard shall not become eligible by spending down to the official poverty guidelines as described in Section 9 of this administrative regulation;

(e) a change of income that occurs after the determination of eligibility of a pregnant woman shall not affect the pregnant woman's eligibility through the remainder of the pregnancy including the postpartum period which ends at the end of the month containing the 60th day of a period beginning on the last day of her pregnancy[;

(f) A targeted low-income child as specified in 907 KAR 1:011, Section 2(3)(h), shall have family income not exceeding 150 percent of the official poverty income guidelines].

(3) The following special income limits and provisions shall apply[be applicable] for a determination of eligibility of a qualified

Medicare beneficiary, specified low-income Medicare beneficiary, qualified disabled and working individual, or Medicare qualified individual group 1 (QI-1).

(a) A qualified Medicare beneficiary shall have income not exceeding 100 percent of the official poverty income guidelines.

(b) A specified low-income Medicare beneficiary shall have income greater than 100 percent of the official poverty income guidelines but not to exceed 120 percent of the official poverty income guidelines.

(c) A Medicare qualified individual group 1 (QI-1) shall have income greater than 120 percent of the official poverty income guidelines but less than or equal to 135 percent of the official poverty income guidelines.

(d) A qualified disabled and working individual shall have income not exceeding 200 percent of the official poverty income guidelines.

(4) Income shall be limited to the allowable amounts for the SSI program for:

(a) A child who lost eligibility for SSI[supplemental security income] benefits due to the change in the definition of childhood disability as established in 42 U.S.C. 1396a(a)(10); or

(b) A person with hemophilia who received a class action settlement as established in 42 C.F.R. 435.122.

(5) Income shall be limited to the allowable amounts for the mandatory or optional state supplement[State Supplementation] program for a pass through recipient as established in 42 C.F.R. 435.135.

(6) The following special income factors shall apply for a Medicaid works individual:

(a) Income for a Medicaid works individual's spouse shall not exceed \$45,000 per year;

(b) A Medicaid works individual's unearned income shall be less than the SSI standard plus twenty (20) dollars monthly; and

(c) The combination of earned and unearned income for a Medicaid works individual shall be less than 250 percent[%] of the official poverty income guidelines.

Section 2.[3.] Income Disregards. In comparing income with the scale established in Section 1[2] of this administrative regulation, gross income shall be adjusted as established in this section.[follows:]

(1) In a TANF[an AFDC] or family related Medicaid case;

(a).[-] The standard work expense of an adult member or out-of-school child shall be deducted from gross earnings;

(b).[-] For a person with either full-time or part-time employment, the standard work expense deduction shall be ninety (90) dollars per month; and

(c).[-] Earnings of an individual attending school who is a child or parent under age nineteen (19) or a child under age eighteen (18) who is a high school graduate shall be disregarded.

(2) For an ABD Medicaid case or a Medicaid works individual, the applicable federal SSI disregards pursuant to 42 U.S.C. 1382a(b) shall apply.

(3) For an individual in a Medicaid eligibility group subject to 42 U.S.C. 1396a(10)(E)(i), (ii), or (iv) or 42 U.S.C. 1396d(p), if an annual Social Security cost-of-living adjustment, Railroad Retirement cost-of-living adjustment, or federal poverty level cost-of-living adjustment causes an individual to be ineligible for Medicaid benefits:

(a) The individual's most recent Social Security cost-of-living adjustment, Railroad Retirement cost-of-living adjustment, or federal poverty level cost-of-living adjustment shall be disregarded; and

(b) The disregard referenced in paragraph (a) of this subsection shall continue until the individual loses Medicaid eligibility for any other reason for three (3) consecutive months.

(4)[In an AFDC or family related Medicaid case, a dependent child care work expense shall be allowed for a child who is living in the home of the caretaker and is related to the caretaker in accordance with 907 KAR 1:011, Section 5(9)(b), for full-time or part-time employment.

(a) The dependent child care work expense shall be deducted after all other disregards have been applied.

~~(b) The dependent child care work expense allowed shall not exceed, per month:~~

~~1. \$200 for full-time or part-time employment per child under age two (2); and~~

~~2. \$175 for full-time employment or \$150 for part-time employment per:~~

~~a. Child age two (2) or above; or~~

~~b. Incapacitated adult.~~

~~(3) For an AFDC-related Medicaid case, a thirty (30) dollar and one-third (1/3) deduction of earned income shall be allowed in accordance with 921 KAR 2:016.~~

~~(4) Income disregards. The income disregards:]~~

~~(a) An ABD Medicaid case shall be the applicable federal SSI disregards pursuant to 42 U.S.C. 1382a(b).[-] and]~~

~~(b) A Medicaid works individual shall be the applicable federal SSI disregards pursuant to 42 U.S.C. 1382a(b).~~

Section 3.~~[4.]~~ Income of the Stepparent or Parent of a Minor Parent referred to as a "Grandparent". An incapacitated stepparent's income, or a grandparent's income, shall be considered in the same manner as for a parent if the stepparent or grandparent is included in the family case. If the stepparent or grandparent living in the home is not being included in the family case, the stepparent's gross income shall be considered available to the spouse or the grandparent's gross income shall be considered available to the minor parent in accordance with the requirements established in this section. The following disregards and exclusions from income shall be applied:

(1) The first ninety (90) dollars of the gross earned income of the stepparent or grandparent who is employed full time or part time;

(2) An amount equal to the appropriate income limitations scale established in Section 2 of this administrative regulation for the appropriate family size, for the support of the stepparent or grandparent and other individuals (not including the spouse or minor parent) living in the home whose needs are not taken into consideration in the Medicaid eligibility determination but are claimed by the stepparent or grandparent as dependents for purposes of determining federal personal income tax liability;

(3) Any amount actually paid by the stepparent or grandparent to an individual not living in the home who is claimed by him as a dependent for purposes of determining his personal income tax liability;

(4) A payment by the stepparent or grandparent for alimony or child support with respect to an individual not living in the household;

(5) Income of a stepparent or grandparent receiving SSI; and

(6) ~~Verified medical expenses for the stepparent or grandparent and his dependents in the home.~~

~~Section 5.] Lump Sum Income. Except as established in Section 8 of this administrative regulation, for a Medicaid case, lump sum income shall be considered as income in the month received.~~

Section 4.[6.] Income Exclusions. (1) Income of a person who is blind or disabled necessary to fulfill a[an approved] plan approved by the United States Social Security Administration to achieve self support, IRWE deduction, or BWE[for achieving self-support (PASS), impairment related work expense (IRWE) deduction, or the blind work expense (BWE)] deduction shall be excluded from consideration.

(2) A payment or benefit from a federal statute, other than SSI benefits, shall be excluded from consideration as income if precluded from consideration in SSI determinations of eligibility by the specific terms of the statute.

(3) A cash payment intended specifically to enable an applicant or recipient to pay for medical or social services shall not be considered as available income in the month of receipt.

(4) A Federal Republic of Germany reparation payment shall not be considered available in the eligibility or post eligibility treatment of income of an individual in a nursing facility or hospital or who is receiving home and community based services under a

waiver program.

(5) A Social Security cost of living adjustment on January 1 of each year shall not be considered as available income for a qualified Medicare beneficiary, specified low-income Medicare beneficiary, qualified disabled and working individual, or Medicare qualified individual group 1 (Q1-1) until after the month following the month in which the official poverty guideline promulgated by the United States Department of Health and Human Services [U.S. Government] is published.

(6) Any amount received from a victim's [victims] compensation fund established by a state to aid victims of crime shall be excluded as income.

(7) A veteran or the spouse of a veteran residing in a nursing facility who is receiving a Veterans Administration (VA) pension benefit shall have ninety (90) dollars:

(a) Excluded as income in the Medicaid eligibility determination; and

(b) Excluded as income in the post eligibility determination process.

(8) Veterans Administration payments for unmet medical expenses [(UME)] and aid and attendance [(A&A)] shall be excluded in a Medicaid eligibility determination for a veteran or the spouse of a veteran residing in a nursing facility.

(a) Veterans Administration payments for unmet medical expenses [(UME)] and aid and attendance [(A&A)] shall be excluded in the post eligibility determination for a veteran or the spouse of a veteran residing in a nonstate-operated nursing facility.

(b) Veterans Administration payments for unmet medical expenses [(UME)] and aid and attendance [(A&A)] shall not be excluded in the post eligibility determination process for a veteran or the spouse of a veteran residing in a state-operated nursing facility.

(9) An Austrian Social Insurance payment based, in whole or in part, on a wage credit granted under Sections 500-506 of the Austrian General Social Insurance Act shall be excluded from income consideration.

(10) An individual retirement account, KEOGH plan, or other tax deferred asset shall be excluded as income until withdrawn.

(11) Disaster relief assistance shall be excluded as income.

(12) Income which is exempted from consideration for purposes of computing eligibility for the comparable money payment program (AFDC or and SSI) shall be excluded.

(13) In accordance with 42 C.F.R. 435.122 and Section 4735 of Pub.L. 105-33, a payment made from a fund established by a settlement in the case of Susan Walker v. Bayer Corporation or payment made for release of claims in this action shall be excluded as income.

(14) In accordance with 42 C.F.R. 435.122, any payment received by a person with hemophilia from a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation" shall be excluded as income.

(15) Family alternatives diversion payments shall be excluded as income.

(16) For an AFDC or family-related Medicaid case, a Medicaid recipient shall have the option to receive a one (1) time exclusion of two (2) months of earned income for new employment or increased wages acquired after approval and reported timely.

(17) For an AFDC-related or a family-related Medicaid case, interest and dividend income shall be excluded.

(18) All monies received by an individual from the Tobacco Master Settlement Agreement [Tobacco Settlement between the states and tobacco manufacturers] shall be excluded.

(17) [(19)] Income placed in a qualifying income trust established in accordance with 42 U.S.C. 1936p(d)(4) and 907 KAR 20:030 [1-650], Section 3(5), shall be excluded.

Section 5. [7.] Consideration of Mandatory or Optional State Supplements [State Supplementary Payments]. For an individual receiving a mandatory or optional state supplement [state supplementary payment], that portion of the individual's income which is in excess of the basic maintenance standard, [(established in Section 1(1)[2(4)] of this administrative regulation,)] shall be applied to the special need which results in

the supplement [supplementary payment].

Section 6. [8.] Pass-through Cases. (1)(a) An increase in a Social Security payment shall be disregarded in determining eligibility for Medicaid benefits if:

1. The increase is a cost of living increase; and

2. The individual would otherwise be eligible for an SSI benefit, mandatory state supplement, or optional state supplement [or state supplementary payment].

(b) An individual who would otherwise be eligible for an SSI benefit, mandatory state supplement, or optional state supplement [or state supplementary payment] shall remain eligible for the full scope of program benefits with no spend-down requirements, as established in Section 7 [9] of this administrative regulation.

(2) For an individual who applied by July 1, 1988, the additional amount specified in 42 U.S.C. 1383c(b) shall be disregarded, meaning that amount of Social Security benefits to which a specified widow or widower was entitled as a result of the recomputation of benefits effective January 1, 1984, and except for which (and subsequent cost of living increases) an individual would be eligible for federal SSI benefits.

Section 7. [9.] Spend-down Provisions. (1) A technically eligible individual or family shall not be required to utilize protected income for medical expenses before qualifying for Medicaid.

(2) (a) An individual with income in excess of the basic maintenance scale established in Section 1 (1)[2(4)] of this administrative regulation may qualify for Medicaid in any part of a three (3) month period in which medical expenses incurred have utilized all excess income anticipated to be in hand during that period.

(b) [(3)] Medical expenses incurred in a period prior to the quarter for which spend-down eligibility is being determined may be used to offset excess income if the medical expenses remain unpaid at the beginning of the quarter and have not previously been used as spend-down expenses.

Section 8. Individual Retirement Account. (1) (a) If an individual reaches the point where the individual is eligible to begin withdrawing from an IRA without suffering a penalty, the individual shall begin withdrawing from the IRA at least the minimum amount determined by the financial institution holding the IRA.

(b) If an individual does not begin withdrawing from an IRA pursuant to paragraph (a) of this subsection, the individual shall be ineligible for Medicaid benefits.

(2) If an individual withdraws funds from an IRA prior to reaching the point where the individual would suffer no penalty for withdrawing funds, the withdrawal shall be considered non-recurring lump sum income.

(3) If an individual withdraws income pursuant to subsection (1)(a) of this section, the income shall be prorated over the period of time the income covers (for example monthly, quarterly, or annually).

Section 9. Applicability. [(4)] The provisions and requirements of this administrative regulation shall:

(1) [(a)] Apply to:

(a) [(1.)] A child in foster care;

(b) [(2.)] An aged, blind, or disabled individual; and

(c) [(3.)] An individual who receives supplemental security income benefits; and

(2) [(b)] Not apply to an individual [(s)]

[(s)] whose Medicaid eligibility is determined:

(a) Using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or

(b) Pursuant to 907 KAR 20:075 [2. Between the ages of nineteen (19) and twenty-six (26) years who:

a. Formerly was in foster care; and

b. Aged out of foster care while receiving Medicaid coverage].

[(2) An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility

standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level].

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 p.m.

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REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes provisions related to Medicaid eligibility income standards except for Medicaid eligibility categories for which the modified adjusted gross income standard is the income standard.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish provisions related to Medicaid eligibility income standards.

(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 provisions related to Medicaid eligibility income standards.

(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 provisions related to Medicaid eligibility income standards.

(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 that the income standards in this administrative regulation do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income (or MAGI) as the income standard or to former foster care individuals who aged out of foster care while receiving Medicaid coverage. Additionally, it contains an amendment which allows for a disregard when an annual Social Security, railroad retirement or federal poverty level (FPL) cost-of-living adjustment (COLA) cause ineligibility for Medicaid benefits; clarifies how individual retirement account (IRA) withdrawals/disbursements are treated; deletes the definitions; and contains language and formatting revisions to comply with KRS Chapter 13A standards. Early IRA withdrawals (meaning withdrawals made before an individual can withdraw funds without being penalized) are treated as lump sum income for the month in which the individual withdrew the money, while income from an IRA withdrawal made after the individual has reached the age where no penalty exists for the withdrawal will be prorated over the period of time the withdrawal covers [quarterly - prorated over three (3) months - or annually - over twelve (12) months - for example.] Individuals for whom a MAGI is the Medicaid income eligibility standard are children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults

under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment after comments clarifies a provision regarding Veterans Affairs pensions; clarifies who approves a plan to achieve self-support, an impairment related work expense (IRWE) deduction plan, or the blind work expense (BWE) deduction plan; and rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations.

(b) The necessity of the amendment to this administrative regulation: Exempting the MAGI population and former foster care individuals from the income standards in this administrative regulation is necessary to comply with an Affordable Care Act mandate. The Affordable Care Act mandate (which establishes a MAGI income eligibility standard for certain individuals and bars the historical Medicaid income standards from being applied to the MAGI population and bars the use of any income standard to the former foster care population. The Social Security/railroad retirement/FPL COLA amendment is necessary to restore Medicaid eligibility for individuals adversely affected by their Social Security/Railroad Retirement COLA exceeding the federal poverty level COLA. Deleting the definitions is necessary as DMS is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house Medicaid eligibility administrative regulations. The IRA withdrawal/disbursement amendment is necessary to clarify existing policy. The amendment after comments is necessary to clarify provisions.

(c) How the amendment conforms to the content of the authorizing statutes: The MAGI and former foster care group exemptions conform to the content of the authorizing statutes by complying with Affordable Care Act mandates. The Social Security/railroad retirement COLA amendment conforms to the content of KRS 194A.050(1) by protecting individuals from losing Medicaid coverage as a result of a Social Security or Railroad Retirement COLA exceeding the federal poverty level COLA. The amendment after comments conforms to the content of the authorizing statutes by clarifying provisions.

(d) How the amendment will assist in the effective administration of the statutes: The MAGI and former foster care group exemptions will assist in the effective administration of the authorizing statutes by complying with Affordable Care Act mandates. The Social Security/railroad retirement COLA amendment will assist in the effective administration of KRS 194A.050(1) by protecting individuals from losing Medicaid coverage as a result of a Social Security or Railroad Retirement COLA exceeding the federal poverty level COLA. The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying provisions.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The following will be affected by the amendment: Medicaid recipients who would have lost eligibility without the amending regarding the cost-of-living adjustment and individuals previously ineligible for Medicaid but who gain eligibility due to the income and resources requirements in this administrative regulation not applying to them. Additionally, the cost-of-living amendments preserve eligibility for anyone now or in the future (indeterminable) who would have lost eligibility. Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) 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.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Those that are exempt from the existing Medicaid income standards will benefit from having standardized (nationwide) and simplified income eligibility standard or no income standard. This will also help lower administrative costs associated with determining eligibility for individuals.

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

(a) Initially: DMS anticipates no cost as a result of exempting the MAGI individuals or former foster care individuals from the requirements in this administrative regulation.

(b) On a continuing basis: The answer provided in paragraph (a) also applies here

(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: Neither an increase in fees nor funding will be necessary to implement the amendments.

(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 is only applied in that the provisions do not apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals as the Affordable Care Act prohibits this.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14), 42 U.S.C. 1396a(r)(2), 42 U.S.C. 1396a(gg), and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

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) authorizes the Cabinet for Health and Family Services 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."

3. Minimum or uniform standards contained in the federal mandate. Effective January 1, 2014, each state's Medicaid program is required – except for certain designated populations – to determine Medicaid eligibility by using the modified adjusted gross income and is prohibited from using any type of expense, income disregard, or any asset or resource test. The populations exempted from the new requirements (and to whom the old requirements continue to apply) include aged individuals [individuals over sixty-five (65) years of age or who receive Social Security Disability Insurance; individuals eligible for Medicaid as a result of being a child in foster care; individuals who are blind or disabled; individuals who are eligible for

Medicaid via another program; individuals enrolled in a Medicare savings program; and medically needy individuals. Also, states are prohibited from continuing to use income disregards, asset tests, or resource tests for individuals who are eligible via the modified adjusted gross income standard. States are also required to create and adopt an income threshold (under the modified adjusted gross income) that ensures that individuals who were eligible for Medicaid benefits prior to January 1, 2014 (the date that the modified adjusted gross income standard is adopted) do not lose Medicaid coverage due to the modified adjusted gross income standard taking effect. 42 U.S.C. 1396a(gg)(2) requires state Medicaid programs to continue (not eliminate or reduce) eligibility standards for individuals under nineteen (19) until October 1, 2019. This provision is known as a "maintenance of effort" provisions and the Centers for Medicare and Medicaid Services (CMS) has also provided guidance establishing the same maintenance of effort requirement for pregnant women. 42 U.S.C. 1396a(a)(10)(A)(i)(IX) creates the new eligibility group comprised of former foster care individuals and bars the application of certain existing Medicaid eligibility requirements to this population.

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. Stricter requirements are 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 Department for Medicaid Services (DMS) will be affected by the amendment to 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the income standards in this administrative regulation nor from exempting former foster care individuals from the standards.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the MAGI individuals from the income standards in this administrative regulation nor from exempting the former foster care individuals from the standards.

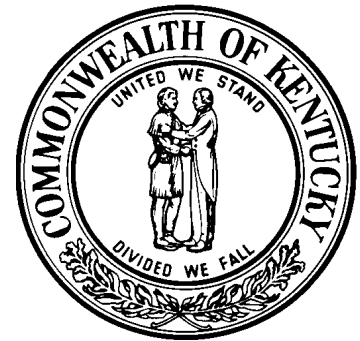
Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

ADMINISTRATIVE REGISTER OF KENTUCKY



LEGISLATIVE RESEARCH COMMISSION
Frankfort, Kentucky

VOLUME 40, NUMBER 8
SATURDAY, FEBRUARY 1, 2014

The submission deadline for this edition of the *Administrative Register of Kentucky* was noon, January 15, 2014.

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MEETING NOTICE: ARRS

The **Administrative Regulation Review Subcommittee** is **tentatively** scheduled to meet February 10, 2014 at 1:30 p.m. in room 149 Capitol Annex. See **tentative agenda** on pages 1525-1527 of this Administrative Register.

Part 2 of 2

VOLUME 40, NUMBER 8 – FEBRUARY 1, 2014

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

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CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amended After Comments)

907 KAR 20:025[907 KAR 1:645]. Resource standards for Medicaid.

RELATES TO: KRS 205.520, 205.619, 304.14-640, 304.14-642, 42 C.F.R. Part 435, 38 U.S.C. 5503, 42 U.S.C. 1396a, 1396b, 1396d, 1397j(b), 1397p

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 435.840, 435.843, and 42 U.S.C. 1396a(l)(3), 1396d

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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the resource standards for determining eligibility for Medicaid benefits.

Section 1.[Definitions. (1) "ABD" means an individual who is aged, blind, or has a disability.

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

(3) "Homestead" means property which an individual:

(a) Has an ownership interest in; and

(b) Uses as his or her principal place of residence.

(4) "~~Individual development account~~" means ~~an account containing funds for the purpose of continuing education, purchasing a first home, business capitalization, or other purposes allowed by federal regulations or clarifications which meets the criteria established in 921 KAR 2:016.~~

(5) "~~K-TAP~~" means ~~Kentucky's version of the federal block grant program of Temporary Assistance for Needy Families (TANF), a money payment program for children who are deprived of parental support or care due to:~~

(a) Death;

(b) Continued voluntary or involuntary absence;

(c) ~~Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are in the home; or~~

(d) ~~Unemployment of one (1) parent if both parents are in the home.~~

(6) "~~Liquid resource~~" means ~~cash, savings accounts, checking accounts, money market accounts, certificates of deposit, bonds and stocks.~~

(7) "~~Long-term care partnership insurance~~" is defined by KRS 304.14-640(4).

(8) "~~Long-term care partnership insurance policy~~" means ~~a policy meeting the requirements established in KRS 304.14-642(2).~~

(9) "~~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 supplemental security income;~~

(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 this administrative regulation.~~

(10) "~~Permanent institutionalization~~" means ~~residing in a nursing facility or intermediate care facility for the mentally retarded and developmentally disabled for six (6) months or more.~~

(11) "~~Poverty level guidelines~~" means ~~the poverty income guidelines updated annually in the Federal Register by the United~~

~~States Department of Health and Human Services, under authority of 42 U.S.C. 9902(2).~~

(12) "~~Real property~~" means ~~land or an interest in land with an improvement, permanent fixture, mineral, or appurtenance considered to be a permanent part of the land, and a building with an improvement or permanent fixture attached.~~

(13) "~~Resources~~" mean ~~cash money and other personal property or real property that:~~

(a) ~~An individual:~~

1. ~~Owns; and~~

2. ~~Has the right, authority, or power to convert to cash; and~~

(b) ~~Is not legally restricted for support and maintenance.~~

(14) "~~SSI~~" means ~~the Social Security Administration Program called supplemental security income.~~

Section 2.] Resource Limitations.(1) For an individual whose Medicaid eligibility is determined using a resource standard[the medically needy as established in 907 KAR 1:011], the upper limit for resources for a family size of:

(a) One (1)[and for a family size of two (2)] shall be \$2,000; or

(b) Two (2) shall be[and] \$4,000 [respectively,] with fifty (50) dollars added for each additional member.

(2)(a)](2) For a pregnant woman or a child meeting the following criteria, resources shall be disregarded for:

(a) A child under age one (1);

(b) A child who is at least age one (1) but under age six (6);

(c) A child who is at least age six (6) but under age nineteen (19) who is eligible under federal poverty level guidelines; or

(d) A targeted low income child, as defined in 42 U.S.C. 1397j(b), from birth to age nineteen (19).

(3) For a qualified disabled and working individual[Medicare beneficiary, specified low-income Medicare beneficiary, qualified working disabled individual, or a Medicare qualified individual], resources shall be limited to the low income subsidy limits established by the Centers for Medicare and Medicaid Services pursuant to 42 U.S.C. 1395w-14(a)(3)(D)][twice the allowable amount for the SSI program].

(b) For a qualified Medicare beneficiary, a specified low-income Medicare beneficiary, or a Medicare qualified individual group 1(QI-1), resources shall be limited to three (3) times the allowable amount for the SSI program.

(4) Resources shall be limited to the amounts allowed in the SSI program for:

(a) A pass-through recipient, as established in 907 KAR 20:020;

(b)[1:640:] A person with hemophilia who received a settlement in a class action lawsuit as described in 907 KAR 20:005;[1:011,] or

(c) A child who lost supplemental security income eligibility due to the change in definition of childhood disability as established in 907 KAR 20:005[1:011, resources shall be limited to the allowable amounts for the SSI program].

(5) [For an AFDC-related Medicaid case, the resource limit shall be \$1,000.

(6)] In accordance with 42 U.S.C. 1396p, an individual shall not be eligible for Medicaid nursing facility services or other Medicaid long-term care services if the individual's equity interest in his or her home exceeds the amount established in 42 U.S.C. 1396p(f)[\$500,000] unless:

(a) The individual has a spouse who is lawfully residing in the individual's home;

(b) The individual has a child under the age of twenty-one (21) who is lawfully residing in the individual's home; or

(c) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home.

(7) There shall be no resource test or standard for:

(a) An individual for whom a modified adjusted gross income is the Medicaid eligibility standard; or

(b) An individual between the ages of nineteen (19) and twenty-six (26) years who:

1. Formerly was in foster care; and

2. Aged out of foster care while receiving Medicaid

~~coverage[Resources for a Medicaid works individual shall not exceed \$5,000 per individual or \$10,000 per couple].~~

Section 2.[3.] Resource Exclusions. (1)(a) A homestead, household or personal effects, ~~or~~~~and~~ farm equipment shall be excluded from consideration without limitation on value.

(b) After permanent institutionalization, property shall cease to be a homestead unless:

1. A spouse or other dependent family member continues to reside there; or

2. A signed statement verifies that the permanently-institutionalized individual intends to return to the homestead.

(c) The signed statement shall:

1.[a.] Be signed by:

a.[(i)] The permanently-institutionalized individual;

b.[(ii)] A representative payee;

c.[(iii)] A person who has power of attorney for the individual;

d.[(iv)] The individual's guardian; or

e.[(v)] Another legal representative; and

2. Be renewed annually~~[b. Require annual renewal].~~

(2) For an adult Medicaid case~~[or a Medicaid works individual]:~~

(a)1. Equity of \$6,000 in income-producing, nonhomestead real property, business or nonbusiness, essential for self-support, shall be excluded from consideration.

2. The value of property, including the tools of a tradesperson or the machinery or livestock of a farmer, shall be excluded from consideration as a resource if the property:

a. Is essential for self-support for the individual or spouse, or family group in the instance of a family with a child; and

b. Is used in a trade or business or by the individual or member of the family group as an employee.

(b) Except as provided in paragraph (c) of this subsection, equity of \$4,500 in automobiles shall be excluded from consideration.

(c) If an automobile is used as a home, for employment, to obtain medical treatment of a specific or regular medical problem, or is specially equipped for use by an individual with a disability, the total value of the automobile shall be excluded.

(d) A payment or benefit from a federal statutory program, other than an SSI benefit, shall be excluded from consideration as a resource if precluded from consideration in an SSI determination of eligibility by the specific terms of the statute.

(3) For an ABD Medicaid case:

(a) Real property or nonreal property shall be excluded from consideration if it can be demonstrated the individual is making a reasonable effort to sell the property at fair market value or for other valuable consideration.

b)1. Property which previously was a homestead shall no longer be considered a homestead at the point an individual becomes permanently institutionalized.

2.a. Non-homestead[Nonhome] property[;] which was previously the homestead property of a permanently-institutionalized individual[;] shall be excluded for six (6) months if there is a verified effort to sell the property at fair market value.

b. If a party on behalf of the permanently institutionalized individual demonstrates to the department, every six (6) months subsequent to the initial six (6)-month period, a continuing effort to sell the property referenced in subparagraph 2 at fair market value, the department shall continue to exclude the property from resource consideration.[2. Additional time to sell the property may be allowed, on a case-by-case basis, if it can be demonstrated that a reasonable effort to sell the property at fair market value within the specified time frame has failed.]

3. Reasonable effort to sell the property shall consist of:

a. Listing the property with a real estate agent if the agent:

(i)[1.] Places a "For Sale" sign on the property which is clearly visible from the nearest public road; and

(ii)[2.] Advertises the property in the local newspaper, a [or on] local television or radio station, or the internet[stations]; or

b. A combination of at least two (2) of the following actions:

(i)[1.] Advertising the property in the local newspaper or on local television or radio stations;

(ii)[2.] Placing a "For Sale" sign on the property which is clearly

visible from the nearest public road;

(iii)[3.] Distributing fliers advertising the property for sale;

(iv)[4.] Posting notices regarding availability of the property on community bulletin boards; or

(v)[5.] Showing the property to interested parties on a continuing basis.

(c) Proceeds from the sale of a home shall be excluded from consideration for three (3) months from the date of receipt if used to purchase another home.

~~(4)[For an AFDC-related Medicaid case, \$1,000 in resources shall be excluded from consideration.]~~

~~(5)[A burial reserve of up to \$1,500 per individual, which may be in the form of a burial agreement, prepaid burial or similar arrangement, trust fund, life insurance policy, savings account, checking account, or other identifiable fund, shall be excluded from consideration.]~~

(a) For an adult Medicaid case, the cash surrender value of life insurance shall be considered if determining the total value of burial reserves.

(b) If a burial fund is commingled with another fund, the applicant shall have thirty (30) days to separately identify the burial reserve amount.

(c) Interest or other appreciation of value of an excluded burial reserve or space shall be excluded as a resource if the amount is left to accumulate as a part of the burial reserve or space.

~~(5)[(6)] A burial trust, burial space, plot, vault, crypt, mausoleum, urn, casket, or other repository which is customarily and traditionally used for the remains of a deceased person shall be excluded from consideration as a countable resource without regard to value.~~

~~(6)[(7) For a family-related or an AFDC-related Medicaid case, proceeds from the sale of a home shall be excluded from consideration for six (6) months from the date of receipt if used to purchase another home.]~~

~~(8) Resources of an individual who is blind or has a disability shall be excluded if the resources are included in an approved plan for achieving self-support (PASS).~~

~~(9)[An individual development account up to a total of \$5,000, excluding interest accruing, shall be excluded from consideration as a resource[for an AFDC-related Medicaid case].]~~

~~(7)[(40)] Disaster relief assistance shall be excluded from consideration.~~

~~(8)[(41)] Cash or in-kind replacement for repair or replacement of an excluded resource shall be excluded from consideration if used to repair or replace the excluded resource within nine (9) months of the date of receipt.~~

~~(9)[(42)] A life interest that a Medicaid applicant or recipient has in real estate or other property shall be excluded from consideration as an available resource.~~

~~(10)[(43)] Real property other than the homestead shall be excluded from consideration if:~~

(a) The property is jointly owned and its sale would cause loss of housing for the other owner or owners;

(b) Its sale is barred by a legal impediment; or

(c) The owner's reasonable efforts to sell by informing the public of his intention to sell the property at fair market value have been unsuccessful.

~~(11)[(44)] A cash payment intended specifically to enable an applicant or recipient to pay for a medical or social service shall not be considered as a resource in the month of receipt or for one (1) calendar month following the month of receipt. If the cash is still being held at the beginning of the second month following its receipt, it shall be considered a resource.~~

~~(12)[(45)] An amount received which is a result of an underpayment or a retroactive payment of benefits from Retirement, Survivors, and Disability Insurance[(RSDI)]-benefits or SSI shall be excluded as a resource for the first six (6) months following the month in which the amount is received.~~

~~(13)[(46)] A federal Republic of Germany reparation payment shall not be considered as an available resource.~~

~~(14)[(47)] An amount received from a victim's compensation fund established by a state to aid victims of crime shall be:~~

(a) Completely excluded as a resource if the individual can

show that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime; or

(b) Excluded as a resource for nine (9) months if the individual can show that the amount was paid for pain and suffering.

~~(15)(18)~~ An Austrian social insurance payment based on a wage credit granted under Sections 500-506 of the Austrian General Social Insurance Act shall be excluded from resource consideration.

~~(16)(19)~~ An individual retirement account, Keogh plan, or other tax deferred asset shall be excluded as a resource until withdrawn.

~~(17)(20)~~ A payment made from a fund established by a settlement in the case of Susan Walker v. Bayer Corporation or payment made for release of claims in this action shall be excluded from consideration as an available resource.

~~(18)(21)~~ A payment received from a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation" shall be excluded from consideration as an available resource.

~~(19)(22)~~ An annuity that is irrevocable and cannot be sold or transferred shall be excluded from consideration as a resource.

~~(20)~~ Except for real property pursuant to subsection (10) of this section, a jointly held resource shall be considered as a countable resource for an applicant.

Section 3.4 Resource Exemptions. (1) A resource which is exempted from consideration for purposes of computing eligibility for the SSI benefits program shall be exempted from consideration by the department.

(2) For an AFDC-related or a family-related Medicaid case, all nonliquid resources shall be exempted.

(3) Resources excluded from consideration during a long-term care eligibility application process and subsequently protected from estate recovery due to payments rendered by a long-term care partnership insurance policy shall:

(a) Be issued on or after the effective date of this administrative regulation; and

(b) Be approved by the Department of Insurance as a long-term care partnership insurance policy in accordance with KRS 304.14-120, 304.14-640, 304.642, 806 KAR 14:007, 806 KAR 17:081, and 806 KAR 17:083.

(3)(4) The exclusion referenced in subsection (2)(3) of this section shall be based on a one (1) dollar for one (1) dollar amount of benefits paid as a direct reimbursement to providers for long-term care expenses or benefits paid on a per diem basis issued directly to the individual.

(4)(5) In accordance with 42 U.S.C. 1396a(r)(2), an individual shall not have to exhaust the benefits of the policy prior to applying for assistance through the department.

(a) This exclusion shall be limited to the amount paid to the applicant or on behalf of the applicant at the time beginning with the month of application for Medicaid benefits.

(b) An applicant shall identify the resources to be excluded[,] equal to the benefit received from the policy when applying for long-term care services through the department.

(c) This exclusion shall not impact an applicant's eligibility for payment for nursing facility services or other long-term care services if the individual's equity interest in the individual's home property exceeds the limits established in 42 U.S.C. 1396p(f) and in Section 1(5)(2)(6) of this administrative regulation.

Section 4. Not Applicable to Individuals Whose Eligibility is Determined Using a Modified Adjusted Gross Income or to Individuals Between the Ages of Nineteen (19) and Twenty-six (26) Who Formerly Were in Foster Care and Aged out of Foster Care. (1) Resources shall not be considered for eligibility purposes for an individual:

(1)(a) For whom a modified adjusted gross income is the Medicaid eligibility standard pursuant to 907 KAR 20:100; or

(2)(b) Between the ages of nineteen (19) and twenty-six (26) years who:

(a) [1] Formerly was in foster care; and

(b) [2] Aged out of foster care while receiving Medicaid coverage; and

(c) For whom the Medicaid eligibility standards are established in 907 KAR 20:075(2) An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level].

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes Medicaid eligibility provisions regarding resource standards.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid eligibility provisions regarding resource standards.

(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 eligibility provisions regarding resource standards.

(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 Medicaid eligibility provisions regarding resource standards.

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

(a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation clarifies that the resource requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income (MAGI) standard as the eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Also, the definitions are deleted and there are language and formatting changes to comply with KRS Chapter 13A requirements and standards. Individuals for whom a MAGI is the Medicaid income eligibility standard are children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment after comments retitles Section 4 for clarity and rewords the section which establishes to which eligibility groups the resource requirements apply to simply refer to the other relevant administrative regulations.

(b) The necessity of the amendment to this administrative

regulation: The amendments exempting the MAGI population and former foster care individuals are necessary to comply with Affordable Care Act mandates. Deleting the definitions is necessary as the Department for Medicaid Services (DMS) is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house Medicaid eligibility administrative regulations. Language and formatting revisions are necessary to comply with KRS Chapter 13A requirements and standards. The amendment after comments is necessary for clarity.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the Affordable Care Act by establishing that resource requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income as the Medicaid eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The amendment after comments conforms to the content of the authorizing statutes by clarifying language.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the Affordable Care Act by establishing that resource requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income as the Medicaid eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying language.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out of foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Individuals who wish to be eligible for Medicaid benefits will continue to need to comply with the Medicaid resource requirements except for individuals whose Medicaid eligibility will be determined using a modified adjusted gross income as the Medicaid eligibility standard.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Those in the MAGI group or former foster care group will benefit by being exempt from the Medicaid resource standards.

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

(a) Initially: DMS anticipates no cost as a result of exempting the MAGI individuals or former foster care individuals from the requirements in this administrative regulation.

(b) On a continuing basis: The answer provided in paragraph (a) also applies here.

(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 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: Neither an increase in fees nor funding will be necessary to implement the amendments.

(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 is only applied in that the provisions do not apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or to former foster care individuals as the Affordable Care Act prohibits this.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14)(C) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet 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.

3. Minimum or uniform standards contained in the federal mandate. The federal law prohibits the application of a resource test to the MAGI population or to the former foster care population.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. It does not impose stricter, additional, or different responsibilities or 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 the amendment to 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 administration 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the resource standards in this administrative regulation nor from exempting former foster care individuals from the standards.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the MAGI individuals from the resource standards in this administrative regulation nor from exempting the former foster care individuals from the standards.

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 Policy and Operations
(Amended After Comments)

907 KAR 20:030. Trust and transferred resource requirements for Medicaid.

RELATES TO: KRS 205.520, 205.619, 205.6322, 304.14-640, 304.14-642, 42 U.S.C. 1396p(b)-f

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6322, 42 C.F.R. 435, 42 U.S.C. 1396a, 1396p

NECESSITY, FUNCTION, AND CONFORMITY: 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 any requirement that may be imposed or opportunity presented by federal law for the provisions of medical assistance to Kentucky's indigent citizenry. KRS 205.6322 requires the cabinet to promulgate administrative regulations to prohibit the sheltering of assets in medical assistance long-term care cases. This administrative regulation establishes trust and transferred resource requirements for Medicaid eligibility determinations for individuals for whom resources are considered for Medicaid eligibility purposes.

Section 1. [Definitions. (1) "Baseline date" means the date the institutionalized individual was institutionalized and applied for Medicaid.

(2) "Cabinet" means the Cabinet for Health and Family Services.

(3) "Fair market value" means an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred.

(4) "Income" means money received from:

(a) Statutory benefits, for example Social Security, Veterans Administration pension, black lung benefits, or railroad retirement benefits;

(b) Pension plans;

(c) Rental property;

(d) Investments; or

(e) Wages for labor or services.

(5) "Institutionalized individual" means an individual with respect to whom payment is based on a level of care provided in a nursing facility (NF) and who is:

(a) An inpatient in:

1. A nursing facility (NF);

2. An intermediate care facility for individuals with an intellectual disability (ICF-IID); or

3. A medical institution; or

(b) Receiving home and community based services (HCBS).

(6) "Long-term care partnership insurance" is defined by KRS 304.14-640(4).

(7) "Long-term care partnership insurance policy" means a policy meeting the requirements established in KRS 304.14-642(2).

(8) "Qualifying Income Trust" or "QIT" means an irrevocable trust established for the benefit of an identified individual in accordance with 42 U.S.C. 1396p(d)(4)(B).

(9) "Resources" mean money and other personal property or real property that an institutionalized individual or institutionalized individual's spouse:

(a) Owns;

(b) Has the right, authority or power to convert to cash; and

(c) Is not legally restricted from using for support and maintenance.

(10) "Transferred resource factor" means an amount that is:

(a) Equal to the average monthly cost of nursing facility services in the state at the time of application. The average

monthly cost shall be the average of the private pay rates for semi-private rooms of all Medicaid-participating nursing facilities; and

(b) Adjusted annually.

(11) "Trust" means a legal instrument or agreement valid under Kentucky state law in which:

(a) A grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee or trustees for the benefit of the grantor or certain designated individuals or beneficiaries; and

(b) A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefit of the beneficiaries.

(12) "Uncompensated value" means the difference between the fair market value at the time of transfer, less any outstanding loans, mortgages, or other encumbrances on the asset, and the amount received for the asset.

Section 2.] Transferred Resources. (1) Transfer of resources on or before August 10, 1993.

(a) If an institutionalized individual applies for Medicaid, a period of ineligibility shall be computed if during the thirty (30) month period immediately preceding the application, but on or before August 10, 1993, the individual or the spouse disposed of property for less than fair market value.

(b) The period of ineligibility shall begin with the month of the transfer and shall be equal to the lesser of:

1. Thirty (30) months; or

2. The number of months derived by dividing the total uncompensated value of the resources transferred by the transferred resource factor at the time of the application.

(2) Transfer of resources after August 10, 1993 and before February 8, 2006.

(a) If an institutionalized individual applies for Medicaid, a period of ineligibility for NF services, ICF IID services, or 1915(c) home and community based services [or ICF-MR-DD services, or HCBS] shall be computed if:

1. During the thirty-six (36) month period immediately preceding the baseline date, but after August 10, 1993, and before March 9, 2007, assets were transferred; or

2. During the sixty (60) month period immediately preceding the baseline date, but after August 10, 1993, and before March 9, 2007, a trust was created whereby the individual or the spouse disposed of property for less than fair market value.

(b) The period of ineligibility shall:

1. Begin with the month of the transfer; and

2. Be equal to the number of months derived by dividing the total uncompensated value of the resources transferred by the transferred resource factor at the time of the application.

(3) Transfer of resources on or after February 8, 2006.

(a) If an institutionalized individual applies for Medicaid, a period of ineligibility for NF services, ICF IID services, or 1915(c) home and community based services [or ICF-MR-DD services, or HCBS] shall be computed if:

1. During the sixty (60) month period immediately preceding the baseline date, but on or after February 8, 2006, assets were transferred; or

2. During the sixty (60) month period immediately preceding the baseline date, but on or after February 8, 2006, a trust was created whereby the individual or the spouse disposed of property for less than fair market value.

(b) The period of ineligibility shall:

1. Begin with the month of Medicaid eligibility for NF services, ICF IID services, or home and community based services [or ICF-MR-DD services, or HCBS]; and

2. Be equal to the number of months derived by dividing the total uncompensated value of the resources transferred by the transferred resource factor at the time of application.

(4) Jointly held resources shall be considered pursuant to 42 U.S.C. 1396p(c)(3).

(5) The addition of another individual's name to a deed shall constitute a transfer of resources.

(6)(a) If a spouse transfers resources that result in an ineligibility period for the institutionalized spouse, the ineligibility period shall be apportioned between the spouses if the spouse is

subsequently institutionalized and a portion of the ineligibility period against the first institutionalized spouse remains.

(b) If one (1) spouse is no longer subject to the ineligibility period, the remaining ineligibility period applicable to both spouses shall be served by the remaining spouse.

(7) The requirements of this subsection shall apply to an agreement in which an individual, prior to institutionalization, employed another person as a caregiver and made payment for all services provided by the caregiver prior to the individual's entry in a nursing facility.

(a) The caregiver agreement shall have:

1. Been notarized;
2. Identified and specified the cost of each caregiver service;
3. Specified that payment shall not have:

a. Been made for a service not recognized in the agreement as a caregiver service; or

b. Duplicated a service provided by another source; and

4. Included a provision that required payment to be made by the caregiver to the individual for the cost of each caregiver service not provided in accordance with the agreement.

(b) The cost of each caregiver service that was not provided in accordance with the agreement and not repaid by the caregiver shall be considered a transfer of resources.

(8)(a) The requirements of this subsection shall apply to resources sold by contractual agreement, including land contracts or contract for deeds.

(b) The contract shall:

1. Be actuarially sound;
2. Not contain balloon payments; and
3. Be without forgiveness of debt if there is termination of the sell.

(c) A contract that does not meet the requirements established in paragraph (b) of this subsection shall be treated as the disposal of assets for less than fair market value.

(9)(a) The requirements of this subsection shall apply to annuities.

(b) A determination shall be completed regarding the purpose of the purchase of an annuity in order to determine if resources were transferred for less than fair market value.

(c)(i) If the expected return on the annuity is commensurate with the life expectancy of the beneficiary, the annuity shall be:

1. Actuarially sound; and
2. Not considered a transfer of resources for less than fair market value.

(d)(i) In accordance with 42 U.S.C. 1396p(c)(1)(F), the purchase of an annuity occurring on or after February 8, 2006 shall be treated as the disposal of assets for less than fair market value unless the cabinet is named:

1. As the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

2.a. A beneficiary in the second position after the community spouse or a minor or disabled child; and

b. A beneficiary in the first position if the community spouse or a representative of the child disposes of any remainder for less than fair market value.

(10) The purchase of an annuity shall be considered a transfer of resources if:

(a) The expected return on the annuity is not commensurate with the life expectancy of the beneficiary, making the annuity not actuarially sound; and

(b) 1. The annuity:

- a. Does not provide substantially equal monthly payments; and
- b. Has a balloon or deferred payment of principal or interest.

2. Payments shall be considered substantially equal if the total annual payment in any year varies by five (5) percent or less from the payment in the previous year.

(11) The policies in this subsection shall apply regarding the transfer of home property.

(a) Transfer of home property to an individual listed in this paragraph shall not constitute a transfer of resources for less than fair market value.

(b) Home property may be transferred to:

1. The spouse;

2. A child who is:

a. Under age twenty-one (21); or

b. Blind or disabled;

3. A sibling who has:

a. Equity interest in the home and lived with the institutionalized individual for one (1) year prior to institutionalization; or

b. A child who:

(i) Resided with the institutionalized individual for two (2) years prior to institutionalization; and

(ii) Provided care to the individual to prevent institutionalization.

(c) Transfer of home property to any individual not listed in paragraph (b)(a) of this subsection shall constitute a transfer of resources for less than fair market value.

(12)(a) For multiple or incremental transfers prior to February 8, 2006, the ineligibility periods shall accrue and run consecutively beginning with the month of the initial transfer.

(b) For multiple or incremental transfers made on or after February 8, 2006, the ineligibility period shall begin with the month of Medicaid eligibility for NF services, ICF IID services, or 1915(c) home and community based services or ICF-MR-DD services, or HCBS.

(13) An individual shall not be ineligible for Medicaid or an institutional type of service:

(a) By virtue of subsections (1) to (10) of this section to the extent that the conditions specified in 42 U.S.C. 1396p(c)(2)(B), (C), and (D) or 907 KAR 20:035[907 KAR 1:655] are met; or

(b) Due to transfer of resources for less than fair market value except in accordance with this section.

(14) [Disposal of a resource.]

(a) The disposal of a resource, including liquid assets, at less than fair market value shall be presumed to be for the purpose of establishing eligibility unless the individual:

1. Shows the transfer was in accordance with 42 U.S.C. 1396p(c)(2)(B) or (C); or

2. Makes a satisfactory showing to the department that the disposal was exclusively for some other purpose.

(b) The value of the transferred resource shall be disregarded if:

1. The transfer is in accordance with 42 U.S.C. 1396p(c)(2)(B) or (C);

2. It is for some reason other than to qualify for Medicaid; or

3. The transferred resource was:

a. Not a homestead; and

b. Considered an excluded resource at the time it was transferred.

(c) If the resource was transferred for an amount equal to the assessed value for tax purposes, the resource shall be considered as being disposed of for fair market value.

(d) If the assessed agricultural value is used for tax purposes, the transfer shall be required to be for an amount equal to the fair market value.

(15)(a) After determining that the purpose of a transfer was to become or remain Medicaid eligible, the cabinet shall add the uncompensated equity value of the transferred resource to other currently held resources to determine if retention of the property would have resulted in ineligibility.

2. For this purpose, the resource considered available shall be the type of resource it was prior to transfer, e.g., if nonhomestead property was transferred, the uncompensated equity value of the transferred property shall be counted against the permissible amount for nonhomestead property.

(b) If retention of the resource would not have resulted in ineligibility, the value of the transferred resource shall be disregarded.

(c) If retention would result in ineligibility, the cabinet shall compute a period of ineligibility for Medicaid or an institutional type of service as provided for in subsections (1) to (10) of this section.

(16)(a) The Uncompensated value shall be excluded from consideration if good cause or undue hardship exists.

(b) A waiver of consideration of the uncompensated amount

shall be granted subject to the criteria established in this subsection.

(c)(a) Good cause shall be determined to exist if an expense or loss was incurred by the individual or family group due to:

1. A natural disaster, for example fire, flood, storm, or earthquake;
2. Illness resulting from accident or disease;
3. Hospitalization or death of a member of the immediate family; or
4. Civil disorder or other disruption resulting in vandalism, home explosions, or theft of essential household items.

(d) An(b) undue hardship shall be determined to exist if:

1. Application of transferred resource penalties deprive an individual of:

- a. Medical care which shall result in an endangerment to the individual's health or life; or
- b. Food, clothing, shelter, or other necessities of life; or

2. The cabinet determines that:

- a. The transfer of resources is not recoverable;
- b. The transfer of resources was not intended by the applicant to result in Medicaid coverage;
- c. The transfer of resources was made in circumstances beyond the applicant's control; or
- d. The applicant would be unable to receive necessary medical care unless an undue hardship exemption is granted.

(e)1.(e)4. The exclusions shall not exceed the amount of the incurred expense or loss.

2. The amount of the uncompensated value to be excluded shall not include any amount which is payable by Medicaid, Medicare, or other insurance.

(f)(e) If an institutionalized individual is subject to a period of ineligibility because the individual or individual's spouse disposed of property, assets, or resources for less than fair market value, the cabinet shall notify the individual in writing and include an explanation of:

1. The criteria upon which an undue hardship waiver may be granted;
2. The process for seeking an undue hardship waiver; and
3. How to appeal an adverse action in accordance with Section 5 of this administrative regulation.

(g)(e) Upon consent of the institutionalized individual or individual's personal representative, the facility in which the individual resides may:

1. Request an undue hardship waiver on behalf of the institutionalized individual;
2. Present information to the cabinet regarding the institutionalized individual's case; and
3. File an appeal in accordance with Section 4[5] of this administrative regulation on behalf of the institutionalized individual if the cabinet denies the facility's request for an undue hardship waiver.

(h)(f) If the cabinet suspends or terminates a recipient's eligibility because the cabinet discovers that the recipient or recipient's spouse transferred resources for less than fair market value and an undue hardship waiver is requested on behalf of the recipient, the cabinet shall provide payments for nursing facility services in order to hold the bed at the facility for up to, but not more than, thirty (30) days from the date of suspension or termination.

(i)(g) If the cabinet decides in favor of a recipient's request for an undue hardship waiver and reverses its previous decision to suspend or terminate eligibility, the cabinet shall cover the recipient's nursing facility services at the facility's full rate for the period the individual is eligible under the undue hardship waiver.

(17) Disclaiming of an inheritance by an individual entitled to the inheritance shall be considered a transfer of resources.

Section 2[3-] Treatment of Resources for a Long-Term Care Applicant who has Long-Term Care Partnership Insurance. (1) The amount of benefits paid by the long-term care partnership insurance policy as a direct reimbursement to providers for long-term care expenses or benefits paid on a per diem basis issued directly to the individual shall be used during the eligibility

determination process to determine the amount of resources the applicant shall have excluded from the eligibility determination and protected from estate recovery in accordance with 907 KAR 20:025[907 KAR 1:645].

(2) If an(h) applicant disposed of a resource for less than fair market value resulting in a transfer penalty, the applicant may choose to apply the allowable exclusion, dollar-for-dollar, to the transferred resources for the purpose of avoiding a penalty.

Section 3[4-] Treatment of Trusts. (1) Regarding a Medicaid qualifying trust created on or before August 10, 1993, if an individual, or the spouse for the individual's benefit, creates, other than by will, a trust or similar legal device with amounts payable to the same individual, the trust shall be considered a "Medicaid qualifying trust" if the trustee of the trust is permitted to exercise discretion as to the amount of the payments from the trust to be paid to the individual.

(a) Except as provided by paragraph (b) of this subsection, the amount considered available to the trust beneficiary shall be the maximum amount the trustee may, using the trustee's discretion, pay in accordance with the terms of the trust, regardless of the amount actually paid.

(b) The cabinet may consider as available only that amount actually paid if to do otherwise would create an undue hardship upon the individual in accordance with Section 1(16)(d)[2(16)(b)] of this administrative regulation.

(2) For purposes of determining eligibility in accordance with Section 1(1)[2(4)] to (10) of this administrative regulation regarding trust agreements, the rules provided for under 42 U.S.C. 1396p(d)(3) shall be met and shall apply to a trust created after August 10, 1993 and established by an individual subject to 42 U.S.C. 1396p(d)(4).

(a) An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the individuals described under 42 U.S.C. 1396p(d)(2)(A)(i), (ii), (iii), and (iv) established the trust other than by a will.

(b)1. If the corpus of a trust includes income or resources of any other person or persons, the trust rules shall apply to the portion of the trust attributable to the income or resources of the individual.

2. In determining countable income and resources, income and resources shall be prorated based on the proportion of the individual's share of income or resources.

(c) Subject to 42 U.S.C. 1396p(d)(4), the trust provisions in 42 U.S.C. 1396p(d) shall be applied in a manner consistent with 42 U.S.C. 1396p(d)(2)(C).

(d)1. Payments made from revocable or irrevocable trusts to or on behalf of an individual shall be considered as income to the individual with the exception of payments for medical costs.

2. Payments for medical care or medical expenses shall be excluded as income.

(e) A trust which is considered to be irrevocable and terminates if action is taken by the grantor shall be considered a revocable trust.

(f) An irrevocable trust which may be modified or terminated by a court shall be considered a revocable trust.

(g) If payment from a revocable or irrevocable trust may be made under any circumstance, the amount of the full payment that could be made shall be considered as a resource including amounts that may be disbursed in the distant future.

(h) Placement of an excluded resource into an irrevocable trust shall not change the excluded nature of the resource.

(i) Placement of a countable resource into an irrevocable trust shall constitute a transfer of resources for less than fair market value.

(3) The treatment of trusts established in this section of this administrative regulation shall be waived if undue hardship criteria is met as established in Section 1(15)(b)[2(15)(b)] of this administrative regulation.

(4) Regarding subsection (1), (2), or (3) of this section, for trusts created on or prior to August 10, 1993, any resources transferred into a previously established trust after August 10, 1993

shall be considered a transfer of resources and subject to an ineligibility period as provided for under Section 1[2] of this administrative regulation using the thirty-six (36) month transfer rules.

(5) An individual may create a qualifying income trust, in accordance with this subsection, to establish financial eligibility for Medicaid.

(a) A transfer of resources shall not apply to a qualifying income trust if:

1. The trust is established in Kentucky for the benefit of an individual;

2. The trust is composed solely of the income of the individual, including accumulated interest in the trust;

3. Upon the death of the individual, the department receives all amounts remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual by Medicaid; and

4. The trust is irrevocable.

(b) The money in a qualifying income trust shall:

1. Be maintained in a separate account; and

2. Not be commingled with any other checking or savings account[accounts].

(c) The corpus of a qualifying income trust and interest generated by the trust shall not be counted as available income for an individual for the determination of Medicaid eligibility.

(d) A qualifying income trust shall state that the funds may only be used for:

1. Valid medical expenses, including patient liability; or

2. The community spouse income allowance established in accordance with 907 KAR 20:035[907 KAR 1:655].

(e) All expenditures from a qualifying income trust shall require verification by the department that the expenditures[they] are allowable expenditures.

(f) Allowable payments from a qualifying income trust shall be made:

1. Every month; or

2. By the end of the month following the month the funds were placed in the trust.

(g) If payments by the qualifying income trust are made for medical care, the individual shall be considered to have received fair market value for income placed in the trust.

Section 4. Applicability. [(1)(a)] The provisions and requirements established in this administrative regulation shall not apply to an individual[;

1.] whose Medicaid eligibility is determined:

(1) Using the modified adjusted gross income standard; or

(2) Pursuant to 907 KAR 20:075[2. Between the ages of nineteen (19) and twenty-six (26) years who:

a. Formerly was in foster care; and

b. Aged out of foster care while receiving Medicaid coverage;

(b) Resources shall not be considered for eligibility purposes for individuals

1. Whose Medicaid eligibility is determined using the modified adjusted gross income standard; or

2. Between the ages of nineteen (19) and twenty-six (26) years who:

a. Formerly was in foster care; and

b. Aged out of foster care while receiving Medicaid coverage;

(2) An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level].

Section 5. Appeal Rights. An appeal of a department decision regarding Medicaid eligibility of an individual based upon application of this administrative regulation shall be in accordance with 907 KAR 1:560[20:065][907 KAR 1:560].

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes Medicaid provisions and requirements regarding trusts and transferred resources for Medicaid eligibility determinations except for individuals for whom the Medicaid eligibility standard is a modified adjusted gross income.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid provisions and requirements regarding trusts and transferred resources for Medicaid eligibility determinations except for individuals for whom the Medicaid eligibility standard is a modified adjusted gross income.

(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 provisions and requirements regarding trusts and transferred resources for Medicaid eligibility determinations except for individuals for whom the Medicaid eligibility standard is a modified adjusted gross income.

(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 provisions and requirements regarding trusts and transferred resources for Medicaid eligibility determinations except for individuals for whom the Medicaid eligibility standard is a modified adjusted gross income.

(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 clarifies that the provisions and requirements do not apply to individuals for whom the Medicaid eligibility standard is a modified adjusted gross income (or MAGI) or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Individuals for whom a MAGI is the Medicaid income eligibility standard are children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment also deletes the definitions. The amendment after comments corrects a couple of formatting mistakes; revises a term to mirror language in federal regulation; and rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant

administrative regulations.

(b) The necessity of the amendment to this administrative regulation: The amendments exempting the MAGI population and former foster care individuals are necessary to comply with Affordable Care Act mandates. Deleting the definitions is necessary as the Department for Medicaid Services (DMS) is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house Medicaid eligibility administrative regulations. Language and formatting revisions are necessary to comply with KRS Chapter 13A requirements and standards. The amendment after comments is necessary to correct a couple of formatting mistakes; revise language to mirror federal regulatory language; and clarify the applicability of the provisions in this administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the Affordable Care Act by establishing that resource requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income as the Medicaid eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The amendment after comments will conform to the content of the authorizing statutes by correcting a couple of formatting mistakes; revising language to mirror federal regulatory language; and clarifying the applicability of the provisions in this administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the Affordable Care Act by establishing that resource requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income as the Medicaid eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The amendment after comments will assist in the effective administration of the authorization statutes by correcting a couple of formatting mistakes; revising language to mirror federal regulatory language; and clarifying the applicability of the provisions in this administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. Individuals who wish to be eligible for Medicaid benefits will continue to need to comply with the Medicaid resource requirements except for individuals whose Medicaid eligibility will be determined using a modified adjusted gross income as the Medicaid eligibility standard or former foster care individuals.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals whose income standard is a modified adjusted gross income or former foster care individuals will benefit due to being exempt from resource requirements.

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

(a) Initially: DMS anticipates no cost as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard or former foster care individuals from the trust and transferred resource requirements established in this administrative regulation.

(b) On a continuing basis: The response in paragraph (a) also applies here.

(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 matching funds from 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 to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is only applied in that the provisions do not apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or to former foster care individuals as the Affordable Care Act prohibits this.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14)(C) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet 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.

3. Minimum or uniform standards contained in the federal mandate. The federal law prohibits the application of a resource test to the MAGI population or to the former foster care population.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. It does not impose stricter, additional, or different responsibilities or 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 the amendment to 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative

regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the trust and transferred resource requirements established in this administrative regulation nor from exempting former foster care individuals from the standards.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the trust and transferred resource requirements established in this administrative regulation nor from exempting former foster care individuals from the standards.

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 Policy and Operations

(Amended After Comments)

907 KAR 20:035. Spousal impoverishment and nursing facility requirements for Medicaid.

RELATES TO: KRS 194A.505, 205.520, 205.619, 304.14-640, 304.14-642, 38 U.S.C. 5503

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. Part 435, 42 U.S.C. 1396a, 1396d, 1396r-5

NECESSITY, FUNCTION, AND CONFORMITY: 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 spousal impoverishment and nursing facility requirements for Medicaid eligibility determinations for individuals for whom resources are considered for Medicaid eligibility purposes.

Section 1. [Definitions. (1) "Assigned support right" means the assignment of the support right of an institutionalized individual to the state or Medicaid Program.

(2) "Community spouse" means the spouse of an institutionalized spouse, who remains at home in the community and is not living in a medical institution or nursing facility or participating in a home and community-based services (HCBS) waiver program.

(3) "Community spouse maintenance standard" means the income standard to which a community spouse's otherwise available income is compared for purposes of determining the amount of the allowance used in the posteligibility calculation.

(4) "Continuous period of institutionalization" means thirty (30) or more consecutive days of institutional care in a medical institution or nursing home or both and may include thirty (30) consecutive days of receipt of HCBS or a combination of both.

(5) "Countable resources" means resources not subject to exclusion in the Medicaid Program.

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

(7) "Dependent child" means the couple's child, including a child gained through adoption, who lives with the community spouse and is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(8) "Dependent parent" means a parent of either member of a couple who lives with the community spouse and is claimed as a

dependent by either spouse under the Internal Revenue Service Code.

(9) "Dependent sibling" means a brother or sister of either member of a couple, including a half brother, half sister or sibling gained through adoption, who resides with the community spouse and is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(10) "Excess shelter allowance" means an amount equal to the difference between the community spouse's verified shelter expenses and the minimum shelter allowance.

(11) "Gross income" means nonexcluded income which would be used to determine eligibility prior to income disregards.

(12) "Income" means money received from statutory benefits (Social Security, Veterans Administration pension, black lung benefits, railroad retirement benefits), pension plans, rental property, investments or wages for labor or services.

(13) "Institutionalized individual" means an individual with respect to whom payment is based on a level of care provided in a nursing facility and who is:

- (a) An inpatient in:
 1. A nursing facility (NF);
 2. An intermediate care facility for individuals with an intellectual disability (ICF-IID); or
 3. A medical institution; or

(b) Receiving home and community based services (HCBS).

(14) "Institutionalized spouse" means an institutionalized individual who is in a medical institution or nursing facility, or participates in an HCBS waiver program and who:

- (a) Has a spouse who is not an institutionalized individual; and
- (b) Is likely to remain institutionalized for at least thirty (30) consecutive days while the community spouse remains out of a medical institution or nursing facility or HCBS waiver program.

(15) "Long-term care partnership insurance" is defined by KRS 304.14-640(4).

(16) "Long-term care partnership insurance policy" means a policy meeting the requirements established in KRS 304.14-642(2).

(17) "Medical institution or nursing facility" means a hospital, nursing facility, or intermediate care facility for individuals with an intellectual disability.

(18) "Minimum shelter allowance" means an amount that is thirty (30) percent of the standard maintenance amount.

(19) "Minor" means the couple's minor child who:

- (a) Is under age twenty-one (21);
- (b) Lives with a community spouse; and
- (c) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(20) "Monthly income allowance" means an amount:

- (a) Deducted in the posteligibility calculation for maintenance needs of a community spouse or other family member; and
- (b) Equal to the difference between a spouse's and other family member's income and the appropriate maintenance needs standards.

(21) "Other family member" means a relative of either member of a couple who is a:

- (a) Minor or dependent child;
- (b) Dependent parent; or
- (c) Dependent sibling.

(22) "Other family member's maintenance standard" means an amount equal to one-third (1/3) of the difference between the income of the other family member and the standard maintenance amount.

(23) "Otherwise available income" means income to which the community spouse has access and control, including gross income that would be used to determine eligibility under Medicaid without benefit of disregards for federal, state and local taxes; child support payments; or other court ordered obligation.

(24) "Resource assessment" means the assessment, at the beginning of the first continuous period of institutionalization of the institutionalized spouse upon request by either spouse, of the joint resources of a couple if a member of the couple enters a medical institution or nursing facility or becomes a participant in an HCBS waiver program.

(25) "Resources" mean money and personal property or real

~~property that an institutionalized individual or institutionalized individual's spouse:~~

~~(a) Owns;~~

~~(b) Has the right, authority or power to convert to cash; and~~

~~(c) Is not legally restricted from using for support and maintenance.~~

~~(26) "Significant financial duress" means a member of a couple has established to the satisfaction of a hearing officer that the community spouse needs income above the level permitted by the community spouse maintenance standard to provide for medical, remedial, or other support needs of the community spouse to permit the community spouse to remain in the community.~~

~~(27) "Spousal protected resource amount" means resources deducted from a couple's combined resources for the community spouse in an eligibility determination for the institutionalized spouse.~~

~~(28) "Spousal share" means one-half (1/2) of the amount of a couple's combined countable resources, up to a maximum of \$60,000 to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g).~~

~~(29) "Spouse" means a person legally married to another under state law.~~

~~(30) "Standard maintenance amount" means one twelfth (1/12) of the federal poverty income guideline for a family unit of two (2) members, with revisions of the official income poverty guidelines applied for Medicaid provided during and after the second calendar quarter that begins after the date of publication of the revisions, multiplied by 150 percent.~~

~~(31) "State spousal resource standard" means the amount of a couple's combined countable resources determined necessary by the department for a community spouse to maintain himself in the community.~~

~~(32) "Support right" means the right of an institutionalized spouse to receive support from a community spouse under state law.~~

~~(33) "Undue hardship" means that Medicaid eligibility of the institutionalized spouse cannot be established on the basis of assigned support rights and the spouse is subject to discharge from the medical institution, nursing facility, or HCBS waiver program due to inability to pay.~~

Section 2.] Resource Assessment. (1) Pursuant to 42 U.S.C. 1396r-5(c)(1)(B), an assessment of the joint resources of an institutionalized spouse and the community spouse shall be made:

(a) Upon request of either spouse at the beginning of a continuous period of institutionalization of the institutionalized spouse; and

(b) Upon receipt of relevant documentation of resources.

(2) Resources that have been protected from estate recovery[,] due to a long-term care partnership insurance policy[,] shall be excluded from the eligibility determination by the eligibility worker at the time of application.

(3) An[The] assessment shall contain the total value of the joint resources and computation of the spousal share.

(4) The department shall complete the assessment within forty-five (45) days following submission of complete documentation or verification.

(5) Upon completion of a[the] resource assessment, each spouse shall:

(a) Receive a copy of the assessment; and

(b) Be notified that the right of appeal of the assessment shall exist at the time the institutionalized spouse applies for Medicaid.

Section 2.[3.] Protection of Income and Resources of the Couple for Maintenance of the Community Spouse. (1) The income provisions established in this subsection shall apply for an individual beginning a continuous period of institutionalization on or after September 30, 1989.

(a) Except as provided in paragraph (b) of this subsection, during a month in which an institutionalized spouse is in the institution, income of the community spouse shall not be deemed available to the institutionalized spouse.

(b) In determining the income of an institutionalized spouse or

community spouse, after the institutionalized spouse has been determined or redetermined to be eligible for Medicaid, the provisions of 42 U.S.C. 1396r-5(b)(2) shall apply.

(2) The resource provisions established in this subsection shall apply for an individual beginning a continuous period of institutionalization on or after September 30, 1989.

(a) Except as provided in subsection (4)(b) of this section, in calculating the resources of an institutionalized spouse at the time of an initial eligibility determination for a benefit under Medicaid, the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse.

(b) The following protected amounts shall be deducted from a couple's combined countable resources at the time of the determination of initial eligibility of the institutionalized spouse:

1. The greater amount of:

a. The spousal share which shall not exceed a maximum of \$60,000 to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g); or

b. The state resource standard; and

2.a. If applicable, an additional amount transferred under a court support order; or

b. If applicable, an additional amount designated by a hearing officer.

(c) The institutionalized spouse shall not be ineligible by reason of resources determined under paragraphs (a) and (b) of this subsection to be available for the cost of care in the following circumstances:

1. The institutionalized spouse has assigned to the department his right to support from the community spouse;

2.a. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment; and

b. The state has the right to bring a support proceeding against a community spouse without the assignment; or

3. The department determines that denial of eligibility would work an undue hardship.

(d) After eligibility for benefits is established for the individual:

1. During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for a Medicaid benefit, the resources of the community spouse shall not be deemed available to the institutionalized spouse; and

2. Resources of the institutionalized spouse protected for the needs of the community spouse shall be considered available to the institutionalized spouse if the resources are not transferred to the community spouse within six (6) months of the initial eligibility determination.

(e) The equity value of an automobile in excess of the limits established by 907 KAR 20:025[1:645] shall not be included as a countable resource.

(3) The provisions established in this subsection shall apply with regard to protecting income for a[the] community spouse.

(a) After an institutionalized spouse is determined or redetermined to be eligible for Medicaid, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

1. A personal needs allowance of forty (40) dollars plus a mandatory withholding from income, including a mandatory payroll deduction that is a condition of employment and federal, state, and local taxes that the government requires the payer to deduct before payment is made to the payee;

2. A community spouse monthly income allowance to the extent income of the institutionalized spouse is made available to, or for the benefit of, the community spouse;

3. A family allowance determined in accordance with the definition of other family member's maintenance standard; and

4. An amount for incurred expenses for medical or remedial care for the institutionalized spouse.

(b)[Establishment of the community spouse income allowance.]1. The community spouse income allowance shall be the sum of the standard maintenance amount and the excess

shelter allowance, not to exceed the community spouse maintenance standard.

2. The community spouse maintenance standard shall be set at \$1,500 per month, to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g).

(c) If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse income allowance for the spouse shall not be less than the amount ordered.

(4) The provisions established in this subsection shall apply ~~regarding~~~~[with regard to]~~ a transfer of resources from an institutionalized spouse.

~~(a)1.~~ An institutionalized spouse may, without regard to the prohibition against disposal of assets for less than fair market value, transfer to the community spouse, or to another for the sole benefit of the community spouse, an amount equal to the spousal protected resource amount to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse.

2. The transfer shall be made as soon as practicable after the initial determination of eligibility, taking into account the time necessary to obtain a court order under paragraph (c) of this subsection.

~~(b)[Establishment of the spousal protected resource amount.]1.~~ The spousal protected resource amount shall be the greater of:

a. The spousal share which shall not exceed a maximum of \$60,000 to be increased for each calendar year in accordance with 42 U.S.C. 1396r-5(g); or

b. The state spousal resource standard.

2. The state spousal resource standard shall be set at \$20,000.~~[;]~~

3. For an individual, the spousal protected resource amount may be a higher amount established by a hearing officer~~[;]~~ or a higher amount transferred under a court order as specified in paragraph (c) of this subsection.

(c) If a court has entered an order against an institutionalized spouse for the support of a community spouse, the prohibition against disposal of assets for less than fair market value shall not apply to the amount of resources transferred pursuant to the order for the support of the spouse.

(5) Except for a transfer of resources to the community spouse as specified in subsection (4) of this section, the transfer of resource policies established by 907 KAR ~~20:030[1:650]~~ shall apply.

(6)(a) The department shall send the notice specified in paragraph (b) of this subsection to both spouses upon a:

1. Determination of eligibility for Medicaid of an institutionalized spouse; or

2. Request by:

a. The institutionalized spouse;

b. The community spouse; or

c. A representative acting on behalf of either spouse.

(b) The notice shall state the:

1.~~[The]~~ Amount of the community spouse monthly income allowance;

2.~~[The]~~ Amount of a family allowance, if any;

3.~~[The]~~ Method of computing the amount of the community spouse resources allowance; and

4.~~[The]~~ Spouse's right to a fair hearing in accordance with 907 KAR ~~20:065[1:560]~~.

(7)(a) Both the institutionalized spouse and community spouse shall be entitled to a fair hearing in accordance with 907 KAR ~~20:065[1:560]~~ if the spouse is dissatisfied with the action of the agency including determination of the following:

1. The community spouse monthly income allowance;

2. The amount of monthly income determined to be otherwise available to the community spouse;

3. The attribution of resources at the time of the initial eligibility determination; or

4. The determination of the community spouse resource allowance.

(b) If either the institutionalized spouse or community spouse establishes during the hearing that the community spouse needs

income above the level otherwise provided by the monthly maintenance needs allowance, due to an exceptional circumstance resulting in significant financial duress, an amount adequate to provide the necessary additional income shall be substituted for the monthly maintenance needs allowance.

(c) If either spouse established during the hearing process that the community spouse resource allowance, in relation to the amount of income generated by an allowance, is inadequate to raise the community spouse's income to the monthly maintenance needs allowance, there shall be substituted for the community spouse resource allowance an amount adequate to provide the monthly maintenance needs allowance.

Section ~~3~~~~[4.]~~ Specified Individuals in Nursing Facilities. For an individual who is aged, blind, or has a disability and who is in a medical institution or nursing facility but does not have a community spouse, the requirements established in this section with respect to income limitations and treatment of income shall apply.

(1) In determining:

~~(a)~~ Eligibility, the appropriate medically needy standard or special income level, disregards, and exclusions from income shall be used; ~~and~~~~[In determining]~~

~~(b)~~ Patient liability for the cost of institutional care, gross income shall be used as provided in subsections (2) and (3) of this section.

~~(2)(a)~~ Income protected for basic maintenance shall be forty (40) dollars monthly plus mandatory withholdings.

~~(b)~~ Mandatory withholdings shall:

1.~~[(a)]~~ Include minimum state and federal taxes; and

2.~~[(b)]~~ Not include court-ordered child support, alimony, or similar payment resulting from an action by the recipient.

~~(3)(a)~~ An amount excluded under a plan to achieve self-support ~~[(PASS)]~~, as an ~~impairment~~~~[income]~~ related work expense ~~[(IRWE)]~~ or a blind work expense (BWE) shall be considered an increased personal needs allowance for a Medicaid recipient except a recipient for whom a quarterly spenddown process as established in 907 KAR ~~20:020[1:640]~~ is applicable.

(4) Income in excess of the amount protected for basic maintenance shall be applied to the cost of care except as provided in this subsection:

(a) Available income in excess of the basic maintenance allowance shall be first conserved as needed to provide for the needs of a minor child up to the appropriate family size amount from the scale as established by 907 KAR ~~20:020, Section 1(1)[1:640, Section 2(1)]~~.

(b) Remaining available income shall be applied to the incurred costs of medical and remedial care that are not subject to payment by a third party (except that the incurred costs may be reimbursed under another public program of the state or political subdivision of the state), including Medicare and health insurance premiums or medical care recognized under state law but not covered under the state's Medicaid plan.

(5) The basic maintenance standard allowed ~~an~~~~[the]~~ individual during the month of entrance into or exit from the nursing facility shall take into account the home maintenance costs.

(6) If an individual loses eligibility for a supplementary payment due to entrance into a participating nursing facility~~[;]~~ and the supplementary payment is not discontinued on a timely basis, the amount of an overpayment shall be considered as available income to offset the cost of care to the Medicaid Program.

~~(7)(a) An SSI benefit payment, mandatory state supplement payment, or optional state supplement[A supplemental security income (SSI) or state supplementation]~~ payment received by a specified institutionalized Medicaid eligible individual in accordance with 42 U.S.C. 1382(e)(1)(G) shall be excluded from consideration as either income or a resource.

~~(b)~~ The payment shall not be used in the posteligibility process to increase the patient liability.

~~(8)(a)~~ Ninety (90) dollars of Veterans Affairs~~[Veteran's Administration (VA)]~~ benefits received by a veteran or the spouse of a veteran shall be excluded from consideration as income.

~~(b)~~ The ninety (90) dollars shall not be counted in the eligibility

or the posteligibility calculation.

(9)[(a)] Veterans Affairs[Administration] payments for unmet medical expenses and aid and attendance shall:

(a) Be excluded in a Medicaid eligibility determination for a veteran or the spouse of a veteran residing in a nursing facility;[-]

(b)[Veterans Administration payments for unmet medical expenses and aid and attendance shall] Be excluded in the posteligibility determination for a veteran or the spouse of a veteran residing in a nonstate-operated nursing facility; and[-]

(c)[Veterans Administration payments for unmet medical expenses and aid and attendance shall] Not be excluded in the posteligibility determination process for a veteran or the spouse of a veteran residing in a state-operated nursing facility.

(10) Income placed in a qualifying income trust established in accordance with 42 U.S.C. 1396p(d)(4) and 907 KAR 20:030, Section 3(5)[1:650, Section 4(5)], shall be counted in the posteligibility determination.

Section 4.[5.] Special Needs Contributions for Institutionalized Individuals. (1) A voluntary payment made by a relative or other party on behalf of a nursing facility resident or patient shall not be considered as available income if made to obtain a special privilege, service, or item not covered by the Medicaid Program.

(2) A special service or item shall include television or telephone service, private room or bath, or a private duty nursing service.

Section 5. Applicability. (1)[(a)] The provisions and requirements established in this administrative regulation shall not apply to an individual[-]

1.[-] whose Medicaid eligibility is determined:

(a) Using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or

(b) Pursuant to 907 KAR 20:075[2. Between the ages of nineteen (19) and twenty-six (26) years who:

a. Formerly was in foster care; and

b. Aged out of foster care while receiving Medicaid coverage].

(2)[(b)] Resources shall not be considered for eligibility purposes for an individual[individuals]:

(a)[1.] Whose Medicaid eligibility is determined using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or

(b)[2.] Between the ages of nineteen (19) and twenty-six (26) years who:

1.[a.] Formerly was in foster care;[and]

2.[b.] Aged out of foster care while receiving Medicaid coverage; and

3. For whom the Medicaid eligibility standards are established in 907 KAR 20:075.

[(2) An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level.]

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 p.m.

CONTACT PERSON: Tricia Orme, Office of Legal Services,

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REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes spousal impoverishment and nursing facility requirements for Medicaid eligibility determinations for individuals for whom resource requirements apply. Resource requirements do not apply to individuals for whom a modified adjusted gross income, or MAGI, is the Medicaid eligibility income standard.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to spousal impoverishment and nursing facility requirements for Medicaid eligibility determinations for individuals for whom resource requirements apply.

(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 spousal impoverishment and nursing facility requirements for Medicaid eligibility determinations for individuals for whom resource requirements apply.

(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 spousal impoverishment and nursing facility requirements for Medicaid eligibility determinations for individuals for whom resource requirements apply.

(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 establishes that the resource requirements do not apply to individuals for whom a modified adjusted gross income (or MAGI) is the Medicaid eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Individuals for whom a MAGI is the Medicaid income eligibility standard are children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment also deletes the definitions and includes language and formatting revisions to comply with KRS Chapter 13A standards. The amendment after comments rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations.

(b) The necessity of the amendment to this administrative regulation: The MAGI-related amendment and former foster care individual amendment is necessary to comply with an Affordable Care Act mandate. Deleting the definitions is necessary as the Department for Medicaid Services (DMS) is creating a definitions administrative regulation for Chapter 20 – the chapter which will house Medicaid eligibility administrative regulations. The language and formatting amendments are necessary to comply with KRS Chapter 13A standards. The amendment after comments is necessary to refer to other relevant administrative regulations.

(c) How the amendment conforms to the content of the authorizing statutes: The MAGI-related amendment and former foster care individual amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate. The language and formatting amendments conform to the content of the authorizing statutes by complying with KRS Chapter 13A standards. The amendment after comments conforms

to the content of the authorizing statutes by referring to other relevant administrative regulations.

(d) How the amendment will assist in the effective administration of the statutes: The MAGI-related amendment and former foster care individual amendment will assist in the effective administration of the authorizing statutes by complying with an Affordable Care Act mandate. The language and formatting amendments conform to the content of the authorizing statutes by complying with KRS Chapter 13A standards. The amendment after comments will assist in the effective administration of the authorizing statutes by referring to other relevant administrative regulations.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) 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.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals in the MAGI group and former foster care individual group will benefit by being exempt from the requirements of this administrative regulation.

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

(a) Initially: DMS anticipates no cost as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard or former foster care individuals from the requirements established in this administrative regulation.

(b) On a continuing basis: The response in paragraph (a) also applies here.

(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 matching funds from 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 to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied in the sense that the requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income or to former foster care individuals as the Affordable Care Act prohibits applying the requirements to these individuals.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14)(C) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet 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.

3. Minimum or uniform standards contained in the federal mandate. The federal law prohibits the application of a resource test to the MAGI population or to the former foster care population.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment neither imposes stricter nor additional nor different responsibilities nor requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment 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 (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the requirements established in this administrative regulation nor from exempting former foster care individuals from the requirements.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the requirements established in this administrative regulation nor from exempting former foster care individuals from the requirements.

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 Policy and Operations

(Amended After Comments)

907 KAR 20:040. Relative responsibility requirements for Medicaid.

RELATES TO: KRS 205.520(3)

STATUTORY AUTHORITY: KRS 194A.030(3)(2), 194A.050(1), 205.520(3), 42 C.F.R. 435 Subparts G, H, I, 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 any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[for the provisions of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes resource and income considerations regarding relatives by which Medicaid eligibility is determined, except for individuals whose eligibility is determined based on modified gross adjusted income or former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits.~~

Section 1. [Definitions. (1) "ABD" means a person who is aged, blind, or disabled.

(2) "Adult scale" means the scale located in 907 KAR 1:640, Section 2(1), establishing Medicaid income limits by family size. (3) "AFDC" means aid to families with dependent children.

(4) "AFDC-related case" means a Medicaid-eligible, categorically-needy individual or group based upon AFDC Program requirements effective since July 16, 1996.

(5) "After the month of separation" means the first day of the month that follows the month in which an individual ceases living in the same household of a Medicaid-eligible family.

(6) "Family-related case" or "family case" means a Medicaid-eligible, medically-needy group based on deprivation and within the medically-needy income level.

(7) "Medically-needy income level" or "MNIL" means the basic maintenance standard used in the determination of Medicaid eligibility for the medically-needy.

(8) "Month of separation" means the month in which an individual ceases living in the same household of a Medicaid-eligible family.

(9) "SSI" means supplemental security income.

(10) "SSI-essential person, spouse, or nonspouse" means an individual necessary to an SSI recipient to enable the SSI recipient to be self-supporting.

Section 2.] Treatment of Income and Resources for a Parent, Dependent Child, ABD Applicant, or Recipient. (1) A spouse shall be considered responsible for a spouse.

(2) A parent shall be considered responsible for a dependent minor child.

(3) Excluding a child who is at least [age] eighteen (18) years of age and [above] who is blind or disabled and for purposes of deeming income and resources, a child under age twenty-one (21) years living with a parent shall be considered a dependent minor child even if the child is emancipated under state law.

(4) Responsibility regarding income and resources shall be determined as follows:

(a) 1. For an ABD applicant or a recipient living with an eligible spouse, total resources and adjusted income of the couple shall be considered in relation to the resource and income limitations for a family size of two (2) unless a dependent lives with the couple.

2. If any dependent lives with a couple, [or if a dependent lives with the couple,] the appropriate family size shall include any dependent living with the couple.

(b) For an ABD applicant or a recipient living with an ineligible spouse, income from the ineligible spouse shall be deemed as available to the eligible spouse as outlined below.

1. Determine the potential spend-down amount of the eligible individual by comparing the countable income, as determined in accordance with 907 KAR 20:020[1:640], to the MNIL for one (1) as shown in 907 KAR 20:020, Section 1(1)[1:640, Section 2(4)].

2. Allocate to other dependents in the household from the ineligible spouse's income an amount equal to one-half (1/2) of the MNIL for a family size of one (1) for each dependent.

3. a. If the ineligible spouse's income is more than the difference between the MNIL for one (1) and MNIL for two (2), combine the income of the ineligible spouse with that of the eligible

individual and compare that figure with the MNIL for one (1) to determine continuing eligibility or the spend-down amount in accordance with clause b. of this subparagraph.

b. If the ineligible spouse's income is less than the difference between MNIL for one (1) and MNIL for two (2), the income shall be disregarded and the income of the eligible individual shall be compared with the MNIL for a family size of one (1).

4. Compare the amount resulting from subparagraph 1 of this paragraph with the result of subparagraph 3 of this paragraph and determine eligibility using the spend-down amount, if any, which is greater.

5. Resources shall be considered in the same manner as for an eligible spouse.

(c) 1. For an ABD couple living apart for any reason and both of whom are concurrently applying for or receiving Medicaid only, income and resources shall be considered in relation to resource and income limitations for a family size of one (1) after the month of separation, or if any other dependent lives with either spouse, the family size shall include any dependent in the month following the month of separation.

2. Eligibility shall be determined on a couple basis for the month of separation.

(d) For an ABD individual living apart from a spouse who is not a recipient of Medicaid only, eligibility shall be determined on a couple basis for the month of separation and on an individual basis after the month of separation.

(e) The following shall be considered a resource for an individual considered to be single in accordance with paragraphs (c) and (d) of this section and who has a jointly-held checking or savings account with his or her spouse:

1. The entire jointly-held checking or savings account if it may be accessed independently of the spouse; or

2. One-half (1/2) of the jointly-held checking or savings account if it may not be accessed independently of the spouse.

(f) [For AFDC-related Medicaid, total resources and adjusted income of a parent and child for whom an application is made shall be considered in relation to limitations for family size, except that the income and resources of an SSI parent and the SSI-essential person spouse whose Medicaid eligibility is based on inclusion in the SSI case shall be excluded.] Resources and income of an SSI-essential person, spouse or nonspouse, whose Medicaid eligibility is not based on inclusion in the SSI case shall be considered.

(g) For a child who is blind or disabled and under eighteen (18) years of age living with a parent (including a stepparent, if applicable), total resources and adjusted income of the parent shall be related to limitations for family size, including the applicant or recipient child and any other dependent child of the parent using the adult scale.

(h) 1. [For AFDC-related Medicaid, income and resources of a parent shall not be considered available to a child living apart from the parent, but any continuing contribution actually made shall be considered as income.] For comparison with the resource and income limitations, a [the] child's individual resources and income shall be considered in relation to a family size of one (1).

2. The following criteria shall be used to determine whether an AFDC-related Medicaid child who has been living with a parent and is institutionalized in a psychiatric facility (mental hospital or psychiatric residential treatment facility) shall be considered as living apart from his parents:

a. [1.] Unless he or she has been in a psychiatric facility for thirty (30) or more days, a child shall be considered as living with a parent. Beginning with the 31st day in a facility, a child shall be considered living apart from his or her parent.

b. [2.] A child who is institutionalized in a psychiatric facility but is legally committed to or in the custody of the Cabinet for Health and Family Services [Families and Children] shall not be considered as living with a parent.

(i) Excluding a child, if an AFDC-related Medicaid recipient has income and resources considered in relation to family size and enters a nursing facility, his or her income and resources shall be considered in the case for up to one (1) year with the individual allowed the basic maintenance standard as established in 907 KAR 20:035[1:655], Section 3(2)[4(2)].

(j)1. If a child in an AFDC-related Medicaid case is in a nursing facility, eligibility of the child shall continue in the case for up to a year but his or her liability for the cost of care shall be determined by:

a. Allowing to the child from his or her own income the basic maintenance standard as established in 907 KAR 20:035[1:655], Section 3(2)[4(2)]; and

b. Considering the remainder available for the cost of care.

2. A welfare payment made to a child under subparagraph 1 of this paragraph shall be disregarded when determining liability for cost of care.

3. The eligibility of the **child[individual]**, with regard to income and resources, shall be determined on the basis of living apart from the other family members if it becomes apparent that the separation will last for more than one (1) year.

~~Section 2.[3. Treatment of Income and Resources of a Stepparent or Parent of a Minor Parent Referred to as a "Grandparent". (1) An incapacitated stepparent's income or a grandparent's income shall be considered in the same manner as for a parent if the stepparent or grandparent is included in the family case.~~

~~(2) If a stepparent or grandparent living in the home is not being included in the family case:~~

~~(a) The stepparent's gross income shall be considered available to the spouse; or~~

~~(b) The grandparent's gross income shall be considered available to the minor parent in accordance with 907 KAR 1:640, Section 4.~~

~~(3) If a stepparent or grandparent has income remaining available after disregards and exclusions are applied, the remaining income shall:~~

~~(a) Not be deemed to a stepchild or grandchild; and~~

~~(b) Be deemed to:~~

~~1. The stepparent's spouse; or~~

~~2. To a minor parent who is a child of the grandparent.~~

~~(4) Eligibility of a stepchild or grandchild shall be determined in the following manner:~~

~~(a) The only income to be considered shall be the income of:~~

~~1. The grandchild and minor parent; or~~

~~2. The stepchild and spouse of the stepparent;~~

~~(b) The budget size shall include the child and parent;~~

~~(c) If there is no excess income, the child shall be eligible; and~~

~~(d) If there is excess income, the excess amount may be spent down in accordance with 907 KAR 1:640, Section 9.~~

~~(5)(a) To determine separate eligibility of a minor parent of a grandchild or spouse of a stepparent:~~

~~1. If the eligibility of the grandparent or stepparent is not to be determined, consider:~~

~~a. The income of the child and his parent; and~~

~~b. The actual amount available for deeming from the grandparent or stepparent.~~

~~2. The budget size shall include the child and parent but not the grandparent or stepparent.~~

~~3. If there is no excess income, the minor parent or spouse of a stepparent shall be eligible.~~

~~4. If there is excess income, the excess amount may be spent down in accordance with 907 KAR 1:640, Section 9.~~

~~(b) If a grandparent of a minor parent or a stepparent (spouse of the parent with children) are to be included in a case, eligibility of the minor parent or spouse shall not be determined separately but shall be determined in combination with that of the grandparent or stepparent.~~

~~1. The combined eligibility of the minor parent and grandparent, or spouse and incapacitated stepparent, shall be determined, as appropriate, using the available income of the:~~

~~a. Grandparent or stepparent;~~

~~b. The minor parent or spouse of the stepparent; and~~

~~c. The grandchild or stepchild.~~

~~2. If the grandparent or incapacitated stepparent is included in the case, the amount excluded for the needs of the grandparent or stepparent in the determination of available income in subsection (2) of this section shall be considered as available income for~~

~~purposes of this determination of eligibility.~~

~~3. If there is no excess income, the minor parent and grandparent or spouse and incapacitated stepparent shall be eligible.~~

~~4. If there is excess income, the excess amount may be spent down in accordance with 907 KAR 1:640, Section 9.~~

~~(6) If eligibility is being determined for an individual or a family group with excess income, uncovered incurred medical expenses of the individual, family group or financially responsible relative shall be used to meet each spend-down amount.~~

~~(7) An incapacitated stepparent's resources or a grandparent's resources shall be considered in the same manner as for a parent if the stepparent or grandparent is included in the family case.~~

~~(8) If a stepparent or grandparent living in the home is not included in the family case, the stepparent's resources shall be considered available to the spouse of the stepparent or the grandparent's resources shall be considered available to the minor parent (child of the grandparent) but not to a stepchild or grandchild.~~

~~(9) Only the resources of the following shall be considered to determine a stepchild or grandchild's eligibility:~~

~~(a) The grandchild and minor parent; or~~

~~(b) The stepchild and parent.~~

~~Section 4.] Companion Cases. (1) If a spouse or parent and child living in the same household apply separately for assistance, relative responsibility shall be taken into consideration.~~

~~(2)[(1)] [For a dependent child application, the income, resources and needs of the parent shall be included in the determination of need of the child even if the parent applies for assistance for himself on the basis of age, blindness, or disability (except as shown in subsection (3) of this section).~~

~~(2)] For a spouse, income and resources of both spouses shall be combined and compared against the medically-needy income and resources limits for a family size of two (2) even though a separate determination of eligibility shall be made for each individual.~~

~~(3)[(2)](3) For a family with a child with a parent eligible for SSI, neither the income, resources, nor needs of the SSI eligible individual shall be included in the determination of eligibility of the children.~~

~~(4)(a)1. A parent in an AFDC-related Medicaid case may request that one (1) or more children be technically excluded from the determination of eligibility due to income while a regular application for Medicaid eligibility is processed for other children in the family group.~~

~~2. In this circumstance, the income and resources of each technically excluded child and each technically excluded child's needs shall be excluded in the budgeting process when determining eligibility of the family group.~~

~~3. A separate spend-down case may be established for each technically excluded child.~~

~~4. The income, resources and needs of the responsible relative or parent shall be included in the budget process.]~~

~~(b)1-] Income disregards, and needs of siblings in the other case may also be included in budgeting for the spend-down case if that works to the advantage of the technically excluded child for whom eligibility is being determined in the spend-down case.~~

Section 3. Applicability. [(1)] The provisions and requirements of this administrative regulation shall not apply to:

(1) A qualified Medicare beneficiary;

(2) A qualified disabled and working individual;

(3) A Medicare qualified individual group 1 (QI-1) individual;

(4) A specified low-income Medicare beneficiary; or

(5) An individual;

1.] whose Medicaid eligibility is determined:

(a) Using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or

(b) Pursuant to 907 KAR 20:075[2. Between the ages of nineteen (19) and twenty-six (26) years who:

a. Formerly was in foster care; and

~~b. Aged out of foster care while receiving Medicaid coverage.~~

~~(2) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be an individual who is:~~

~~(a) A child under the age of nineteen (19) years, excluding children in foster care;~~

~~(b) A caretaker relative with income up to 133 percent of the federal poverty level;~~

~~(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;~~

~~(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:~~

~~1. Does not have a dependent child under the age of nineteen (19) years; and~~

~~2. Is not otherwise eligible for Medicaid benefits; or~~

~~(e) A targeted low income child with income up to 150 percent of the federal poverty level].~~

Section 4.[2- Excess income in the spend-down case may be spent down using uncovered incurred medical care costs of a financially responsible relative or any member of the family.

(5) The needs of a sibling living in the household under the age of twenty-one (21) not requesting assistance, may be included in an AFDC-related Medicaid case if it works to the advantage of the family group.

Section 5-] Appeals. [(1) An appeal of a negative action taken by the Department for Medicaid Services regarding a Medicaid recipient shall be in accordance with 907 KAR 1:563.

(2)] An appeal of a negative action taken by the Department for Medicaid Services regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 p.m.

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REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes Medicaid program resource and income eligibility standards and requirements regarding relatives.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid program resource and income eligibility standards and requirements regarding relatives in accordance with federal law and regulation and as authorized by KRS 194A.030(2) which establishes the Department for Medicaid Services as the commonwealth's single state agency for administering the federal Social Security Act.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Medicaid program resource and income eligibility standards and requirements regarding relatives.

(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 KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing Medicaid program resource and income eligibility standards and requirements regarding relatives.

(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 establishes that the standards and

requirements do not apply to individuals for whom a modified adjusted gross income (or MAGI) is the eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The MAGI population includes children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. Additionally, the amendment deletes the definitions and includes language and formatting revisions to comply with KRS Chapter 13A requirements. The amendment after comments contains wording/formatting changes to comply with KRS Chapter 13A requirements; rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations; and clarifies that the relative responsibility requirements in the administrative regulation do not apply to qualified Medicare beneficiaries (QMBs), qualified disabled and working individuals, Medicare qualified individual group 1 (QI-1) individuals, or specified low-income Medicare beneficiaries.

(b) The necessity of the amendment to this administrative regulation: The amendments are necessary to comply with the Affordable Care Act regarding populations to which the eligibility requirements established in this administrative regulation do not apply. Deleting definitions is necessary as the Department for Medicaid Services (DMS) is creating a definitions administrative regulation to establish definitions for Chapter 20 – the new chapter which will house Medicaid eligibility administrative regulations. The amendment after comments is necessary to comply with KRS Chapter 13A requirements and for clarity. The amendment regarding Medicare beneficiaries (QMBs), qualified disabled and working individuals, Medicare qualified individual group 1 (QI-1) individuals, and specified low-income Medicare beneficiaries is necessary as federal law bars the application of the relative responsibility requirements to these individuals.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act provision that excludes the eligibility requirements from applying to individuals for whom a modified adjusted gross income is the Medicaid income eligibility standard or to former foster care individuals. The amendment after comments conforms to the content of the authorizing statutes by complying with KRS Chapter 13A requirements, by clarifying provisions, and by complying with federal law.

(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 complying with an Affordable Care Act provision that excludes the eligibility requirements from applying to individuals for whom a modified adjusted gross income is the Medicaid income eligibility standard or to former foster care individuals. The amendment after comments will assist in the effective administration of the authorizing statutes by complying with KRS Chapter 13A requirements, by clarifying provisions, and by complying with federal law.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include

3,358 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) 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 amendment requires no action to be taken by affected individuals.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The amendment imposes no cost on the affected individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals exempt from requirements in this administrative regulation will benefit due to the clarification that the requirements do not apply to them.

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

(a) Initially: DMS anticipates no cost as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard or former foster care individuals from the requirements established in this administrative regulation.

(b) On a continuing basis: The response in paragraph (a) also applies here.

(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 matching funds from 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 to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied in the sense that the requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income or to former foster care individuals as the Affordable Care Act prohibits applying the requirements to these individuals.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14)(C) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet 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.

3. Minimum or uniform standards contained in the federal mandate. The federal law prohibits the application of a resource test to the MAGI population or to the former foster care population.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment neither imposes stricter nor additional nor different responsibilities nor requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment 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 (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(10) and 42 U.S.C. 1396a(e)(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.

(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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the requirements established in this administrative regulation nor from exempting former foster care individuals from the requirements.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the requirements established in this administrative regulation nor from exempting former foster care individuals from the requirements.

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 Policy and Operations

(Amended After Comments)

907 KAR 20:045. Special income requirements for hospice and home and community based services [(HCBS)].

RELATES TO: KRS 205.520, 42 C.F.R. Part 435, 38 U.S.C. 5503, 42 U.S.C. 1396a, n

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(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 special income requirements for home and community based waiver and hospice services, except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage.

Section 1.[Definitions. (1) "Basic maintenance" means the amount of income that may be retained by the applicant for living and personal expenses. (2) "Categorically needy" means an individual with income below 300 percent of the supplemental security income (SSI) standard who has been receiving hospice or HCBS for thirty (30) consecutive days.

(3) "HCBS" means home and community based services.

(4) "Institutionalized" means residing in a nursing facility or receiving hospice or HCBS benefits.

(5) "Special income level" means the amount which is 300 percent of the SSI standard.

(6) "SSI" means the Social Security Administration Program called supplemental security income.

(7) "SSI general exclusion" means the twenty (20) dollars disregard from income allowed by the Social Security Administration in an SSI determination.

(8) "SSI standard" means the amount designated by the Social Security Administration as the federal benefit rate.

Section 2.] Special Provisions for Recipients Participating in a 1915(c) Home and Community Based Services[the HCBS] Waiver Program. (1) Medicaid eligibility for a recipient receiving 1915(c) home and community based services[participant under HCBS] shall be determined if necessary to establish eligibility for Medicaid benefits for a case with income in excess of the basic maintenance standard taking into consideration the special provisions established in:

(a) This section; and

(b) 907 KAR 20:035[~~in 907 KAR 1:655~~].

(2) Income protected for the basic maintenance of a 1915(c) home and community based services waiver[an HCBS] program participant who is eligible as medically needy or under the special income level established in this section shall be the standard used for an individual in the Federal SSI Program in addition to the SSI general exclusion from income.

(3) A 1915(c) home and community based services waiver[An HCBS] program participant who participates in a 1915(c) home and community based services waiver[the HCBS] program for thirty (30) consecutive days, including the actual days of institutionalization within that period, and who has income which does not exceed the special income level shall be determined to be eligible as categorically needy under the special income level.

(4) If a Supports for Community Living (SCL) Program participant has income in excess of the special income level, eligibility of the participant shall be determined on a monthly spenddown basis with the cost of SCL services projected.

(5) Institutional deeming rules shall apply in accordance with 907 KAR 20:035[1:655].

(6)(a) In the posteligibility determination of available income, the basic maintenance needs allowance shall include a mandatory withholding from income.

(b) Mandatory withholdings shall:

1. ~~(a)~~ Include state and federal taxes; and

2. ~~(b)~~ Not include child support, alimony, or a similar payment resulting from an action by the recipient.

(7) A veteran or the spouse of a veteran who is receiving services in a home and community based waiver program and who is receiving a Veterans Affairs[~~Veteran's Administration (VA)~~] benefit shall have ninety (90) dollars excluded from the eligibility and posteligibility determination process.

(8) Veterans Affairs[~~Administration~~] payments for unmet medical expenses (UME) and aid and attendance (A&A) shall be excluded in a Medicaid eligibility and posteligibility determination for a veteran or the spouse of a veteran receiving services from a home and community based waiver program.

(9) Income placed in a qualifying income trust established in accordance with 42 U.S.C. 1396p(d)(4) and 907 KAR 20:030[1:650], Section 2(5)[3(5)], shall not be excluded in the posteligibility determination.

Section 2.[3.] Special Provisions for Hospice Recipients. Medicaid eligibility for a participant in the Medicaid Hospice Program shall be determined in accordance with the provisions [by taking into consideration the special provisions contained] in this section.

(1) Income protected for basic maintenance shall be:

(a) The SSI standard and the SSI general exclusion from income for the hospice participant in the posteligibility determination for a noninstitutionalized individual eligible on the

basis of the special income level;

(b) The usual medically needy standard established in 907 KAR 20:020[1:640], Section 1[2], plus the SSI general exclusion for a noninstitutionalized medically needy participant, who shall spenddown on a quarterly basis;

(c) The medically needy standard for the appropriate family size plus the SSI general exclusion for the institutionalized medically needy;

(d) Forty (40) dollars per month for the hospice participant institutionalized in a long-term care facility;

(e) For a veteran or the spouse of a veteran who is receiving services from a hospice and who is receiving a Veterans Affairs[~~Veteran's Administration (VA)~~] benefit, ninety (90) dollars, which shall be excluded from the eligibility and posteligibility determination process; or

(f) The amount of Veterans Affairs[~~Administration~~] payments for unmet medical expenses (UME) and aid and attendance (A&A), which shall be excluded in a Medicaid eligibility and posteligibility determination for a veteran or the spouse of a veteran receiving services from a hospice.

(2) If eligibility is determined for an institutionalized spenddown case, the attributed cost of care against which available income of the hospice participant shall be applied shall be the hospice routine home care per diem for the hospice providing care as established by 42 U.S.C. 1395f(i) plus the private pay rate for the nursing facility.

(3) Eligibility shall continue on the same monthly basis as for an institutionalized individual if the recipient is eligible based on the special income level.

(4) A hospice participant shall be eligible for a benefit based on this section if he has elected coverage under the Medicaid Hospice Program rather than the regular Medicaid Program.

(5) Institutional deeming rules shall apply in accordance with 907 KAR 20:035[1:655] with regard to the categorically needy including a participant eligible on the basis of the special income level.

(6) Community deeming procedures shall be used in accordance with 907 KAR 20:040[1:660] for a noninstitutionalized hospice recipient who is:

(a) A medically needy individual, who shall spenddown on a quarterly basis; and

(b) Not eligible under the special income level.

(7)(a) In the posteligibility determination of available income, the basic maintenance needs allowance shall include a mandatory withholding from income.

(b) Mandatory withholdings shall:

1. ~~(a)~~ Include state and federal taxes; and

2. ~~(b)~~ Not include child support, alimony, or a similar payment resulting from an action by the recipient.

(8) Income placed in a qualifying income trust established in accordance with 42 U.S.C. 1396p(d)(4) and 907 KAR 20:030[1:650], Section 2(5)[3(5)], shall not be excluded in the posteligibility determination.

Section 3. Applicability. [(1)] The provisions and requirements of this administrative regulation shall not apply to an individual:

1.] whose Medicaid eligibility is determined:

(1) Using the modified adjusted gross income standard pursuant to 907 KAR 20:100; or

(2) Pursuant to 907 KAR 20:075[2. Between the ages of nineteen (19) and twenty-six (26) years who:

a. Formerly was in foster care; and

b. Aged out of foster care while receiving Medicaid coverage.

(2) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be an individual who is:

(a) A child under the age of nineteen (19) years, excluding children in foster care;

(b) A caretaker relative with income up to 133 percent of the federal poverty level;

(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up

to sixty (60) days after delivery;

(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

1. Does not have a dependent child under the age of nineteen (19) years; and

2. Is not otherwise eligible for Medicaid benefits; or

(e) A targeted low income child with income up to 150 percent of the federal poverty level].

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 p.m.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes Medicaid special income requirements for 1915(c) home and community based waiver services and hospice services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid special income requirements for 1915(c) home and community based waiver services and hospice 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 Medicaid special income requirements for 1915(c) home and community based waiver services and hospice 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 authorizing statutes by establishing Medicaid special income requirements for 1915(c) home and community based waiver services and hospice 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 establishes that the requirements do not apply to individuals for whom a modified adjusted gross income (or MAGI) is the Medicaid income eligibility standard or to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. The MAGI individuals include children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment also deletes the definitions and contains language and formatting revisions to comply with KRS Chapter 13A requirements. The amendment after comments rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations.

(b) The necessity of the amendment to this administrative regulation: The MAGI-related amendment and former foster care individuals' amendment is necessary to comply with Affordable Care Act mandates. Deleting the definitions is necessary as DMS is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house all Medicaid eligibility administrative regulations. Language and formatting amendments are necessary to comply with KRS Chapter 13A standards. The amendment after comments is necessary for clarity.

(c) How the amendment conforms to the content of the authorizing statutes: The MAGI-related amendment and former foster care individuals' amendment conforms to the content of the authorizing statutes by complying with Affordable Care Act

mandates. The language and formatting amendments conform to KRS Chapter 13A standards. The amendment after comments conforms to the content of the authorizing statutes by adding clarity.

(d) How the amendment will assist in the effective administration of the statutes: The MAGI-related amendment and former foster care individuals' amendment will assist in the effective administration of the authorizing statutes by complying with Affordable Care Act mandates. The language and formatting amendments will assist in the effective administration of the authorizing statutes by complying with KRS Chapter 13A standards. The amendment after comments will assist in the effective administration of the authorizing statutes by adding clarity.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) 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 amendment requires no action to be taken by affected individuals.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The amendment imposes no cost on the affected individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals exempt from the special income requirements in the administrative regulation will benefit due to the clarification that the requirements do not apply to them.

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

(a) Initially: DMS anticipates no cost as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard or former foster care individuals from the requirements established in this administrative regulation.

(b) On a continuing basis: The response in paragraph (a) also applies here.

(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 matching funds from 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 to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied in the sense that the requirements do not apply to individuals whose Medicaid eligibility is determined using a modified adjusted gross income or to former foster care individuals as the Affordable Care Act prohibits applying the requirements to these individuals.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal

mandate. 42 U.S.C. 1396a(e)(14), 42 U.S.C. 1396a(r)(2), and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

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) authorizes the Cabinet for Health and Family Services 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."

3. Minimum or uniform standards contained in the federal mandate. Effective January 1, 2014, each state's Medicaid program is required – except for certain designated populations - to determine Medicaid eligibility by using the modified adjusted gross income and is prohibited from using any type of expense, income disregard, or any asset or resource test. The populations exempted from the new requirements (and to whom the old requirements continue to apply) include aged individuals [individuals over sixty-five (65) years of age or who receive Social Security Disability Insurance; individuals eligible for Medicaid as a result of being a child in foster care; individuals who are blind or disabled; individuals who are eligible for Medicaid via another program; individuals enrolled in a Medicare savings program; and medically needy individuals. Also, states are prohibited from continuing to use income disregards, asset tests, or resource tests for individuals who are eligible via the modified adjusted gross income standard.

States are also required to create and adopt an income threshold (under the modified adjusted gross income) that ensures that individuals who were eligible for Medicaid benefits prior to January 1, 2014 (the date that the modified adjusted gross income standard is adopted) do not lose Medicaid coverage due to the modified adjusted gross income standard taking effect. 42 U.S.C. 1396a(a)(10)(A)(i)(IX) creates a new mandated eligibility group comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage and bars the application of an income standard or resource standard to the individuals.

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. Stricter requirements are 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 Department for Medicaid Services (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This 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 does not expect the amendment to this administrative

regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the requirements established in this administrative regulation nor from exempting former foster care individuals from the requirements.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the requirements established in this administrative regulation nor from exempting former foster care individuals from the requirements.

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 Policy and Operations (Amended After Comments)

907 KAR 20:050. Presumptive eligibility[for pregnant women].

RELATES TO: KRS 205.520(3), 205.592, 42 U.S.C. 1396a(a)(47), r-1

STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050(1), 205.520(3)(2), 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, 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[for the provision of medical assistance to Kentucky's indigent citizenry]. KRS 205.592 establishes Medicaid eligibility requirements for pregnant women and children up to age one (1). This administrative regulation establishes requirements for the determination of presumptive eligibility and the provision of services to individuals[pregnant women] deemed presumptively eligible for Medicaid-covered services.

Section 1.[Definitions. (1) "Ambulatory prenatal care" means health-related care furnished to a presumed eligible pregnant woman provided in an outpatient setting.

(2) "Cabinet" means the Cabinet for Health and Family Services.

(3) "DCBS" means the Department for Community Based Services.

(4) "Department" means the Department for Medicaid Services or its designated agent.

(5) "Presumptive eligibility" means eligibility granted for Medicaid-covered services as specified in Section 6 of this administrative regulation to a qualified pregnant woman based on an income screening performed by a qualified provider.

(6) "Qualified provider" means a provider who:

(a) Is currently enrolled with the department;

(b) Has been trained and certified by the department to grant presumptive eligibility to pregnant women; and

(c) Provides services of the type described in 42 U.S.C.

1396d(a)(2)(A) or (B) or (9).

Section 2.] Providers Eligible to Grant Presumptive Eligibility.

(1) A determination of presumptive eligibility regarding:

(a) A pregnant woman shall be made by a qualified provider who is:

1. [(1)] A family or general practitioner;
2. [(2)] A pediatrician;
3. [(3)] An internist;
4. [(4)] An obstetrician or gynecologist;
5. [(5)] A physician assistant;
6. [(6)] A certified nurse midwife;
7. [(7)] An advanced practice registered nurse[practitioner];
8. [(8)] A federally-qualified health care center;
9. [(9)] A primary care center;
10. [(10)] A rural health clinic; or
11. [(11)] A local health department; or

(b) An individual whose income standard for Medicaid eligibility purposes is a modified adjusted gross income shall be made by an inpatient hospital participating in the Medicaid program.

(2) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be as established in:

(a) An individual:

1. Who is:

a. A child under the age of nineteen (19) years, excluding children in foster care;

b. A caretaker relative with income up to 133 percent of the federal poverty level;

c. A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

d. An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

(i) Does not have a dependent child under the age of nineteen (19) years; and

(ii) Is not otherwise eligible for Medicaid benefits; or

e. A targeted low-income child with income up to 150 percent of the federal poverty level; and

(b) In accordance with] 907 KAR 20:100.

Section 2.[3.] Provider Responsibilities. (1) A qualified provider who determines that an individual[a pregnant woman] is presumptively eligible for Medicaid based on criteria established in Section 3[4] of this administrative regulation shall:

(a) Notify the department and obtain an authorization number;

(b) Inform the individual[woman] at the time the determination is made that the individual[she] is required to make an application for Medicaid benefits through the individual's[her] local DCBS office;

(c) Issue presumptive eligibility identification to the presumed eligible individual[woman]; and

(d) Maintain a record of the presumptive eligibility screening for each applicant.

(2) If an individual[a woman] is determined not to be presumptively eligible, the qualified provider shall inform the individual[woman] of the following in writing:

(a) The reason for the determination;

(b) That the individual[she] may file an application for Medicaid if the individual[she] wishes to have a formal determination made; and

(c) The location of the individual's[her] local DCBS office.

Section 3.[4.] Eligibility Criteria. Presumptive eligibility may be granted to:

(1) A woman if she:

a. [(1)] Is pregnant;

b. [(2)] Is a Kentucky resident;

c. Does not have income exceeding 195[185] percent of the federal poverty level[(3) Meets income guidelines established in 907 KAR 1:640, Section 2(2)(a)];

d. [(4)] Does not currently have a pending Medicaid application on file with the DCBS;

e. [(5)] Is not currently enrolled in Medicaid;

f. [(6)] Has not been previously granted presumptive eligibility for the current pregnancy; and

g. [(7)] Is not an inmate of a public institution, except as established in 907 KAR 20:005, Section 7(2); or

(2) An individual whose Medicaid income eligibility standard is a modified adjusted gross income if the individual:

a. Is a Kentucky resident;

b. Does not have income exceeding:

1. 133 percent of the federal poverty level; or

2. 150 percent of the federal poverty level if the individual is a targeted low-income child;

c. Does not currently have a pending Medicaid application on file with the DCBS;

d. Is not currently enrolled in Medicaid; and

e. Is not an inmate of a public institution except as established in 907 KAR 20:005, Section 7(2).

Section 4.[5.] Presumptive Eligibility Period. (1) Presumptive eligibility for an individual shall begin on the date on which a qualified provider:

(a) Determines that the individual[a woman] is presumptively eligible based on the criteria specified in Section 3[4] of this administrative regulation if the qualified provider obtains an authorization number from the department on:

1. That day; or

2. If the department is closed, the next business day the department is open; or

(b) Obtains an authorization number from the department if it is not the day specified in paragraph (a) of this subsection.

(2) The presumptive eligibility period shall end on:

(a) The day preceding the date the presumptively-eligible individual[woman] is granted full eligibility in the Medicaid Program by the DCBS; or

(b) The last day of the[second] month following the month in which a qualified provider made the presumptive eligibility determination if the[a] presumed eligible individual[woman]:

1. Does not apply for the full Medicaid benefit package; or

2. Applies for and is found ineligible for the full Medicaid benefit package.

(3) To illustrate the presumptive eligibility period, if an individual became presumptively eligible on July 7, 2014, the individual would remain presumptively eligible through August 31[September 30], 2014.

(4) For a woman who gains presumptive eligibility by being pregnant, only one (1) presumptive eligibility period shall be granted for each episode of pregnancy.

Section 5.[6.] Covered Services. (1)[a] Payment for a covered service provided to a presumptively-eligible individual[pregnant woman] shall be in accordance with the current Medicaid reimbursement policy for the service unless the service is provided to an individual who is enrolled with a managed care organization[reimbursement].

(b) A managed care organization:

1. Shall not be required to reimburse in the same manner or amount as the department reimburses for a Medicaid-covered service provided to a presumptively eligible individual; or

2. May elect to reimburse in the same manner or amount as the department reimburses for a Medicaid-covered service provided to a presumptively eligible individual.

(2) Covered services for a presumptively-eligible;

a. Pregnant woman shall be limited to ambulatory prenatal care services delivered in an outpatient setting and shall include:

1. [(a)] Services furnished by a primary care provider, including:

a. [(1)] A family or general practitioner;

b. [(2)] A pediatrician;

c. [(3)] An internist;

d. [(4)] An obstetrician or gynecologist;

e. [(5)] A physician assistant;

f. [(6)] A certified nurse midwife; or

g. [(7)] An advanced practice registered nurse[practitioner];

2. [(b)] Laboratory services provided in accordance with 907

KAR 10:014[1:014] and 907 KAR 1:028;

3.[(e)] X-ray services provided in accordance with 907 KAR 10:014[1:014] and 907 KAR 1:028;

4.[(d)] Dental services provided in accordance with 907 KAR 1:026, Section 2(1) and (2);

5.[(e)] Emergency room services provided in accordance with 907 KAR 10:014[Section 1(1)(e)];

6.[(f)] Emergency and nonemergency transportation provided in accordance with 907 KAR 1:060;

7.[(g)] Pharmacy services provided in accordance with 907 KAR 1:019[1:019E];

8.[(h)] Services delivered by rural health clinics provided in accordance with 907 KAR 1:082;

9.[(i)] Services delivered by primary care centers and federally-qualified health care centers provided in accordance with 907 KAR 1:054; or

10.[(j)] Primary care services delivered by local health departments provided in accordance with 907 KAR 1:360; or

(b) Individual who is not a pregnant woman shall include:

1. Services furnished by a primary care provider, including:

a. A family or general practitioner;

b. A pediatrician;

c. An internist;

d. An obstetrician or gynecologist;

e. A physician assistant;

f. A certified nurse midwife; or

g. An advanced practice registered nurse;

2. Laboratory services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

3. X-ray services provided in accordance with 907 KAR 10:014 and 907 KAR 1:028;

4. Dental services provided in accordance with 907 KAR 1:026, Section 2(1) and (2);

5. Emergency room services provided in accordance with 907 KAR 10:014;

6. Emergency and nonemergency transportation provided in accordance with 907 KAR 1:060;

7. Pharmacy services provided in accordance with 907 KAR 1:019;

8. Services delivered by rural health clinics provided in accordance with 907 KAR 1:082;

9. Services delivered by primary care centers and federally-qualified health care centers provided in accordance with 907 KAR 1:054;

10. Primary care services delivered by local health departments provided in accordance with 907 KAR 1:360; or

11. Inpatient or outpatient hospital services provided by a hospital.

Section 6.[7.] Appeal Rights. (1) The appeal rights of the Medicaid Program shall not apply if an individual[a woman] is:

(a) Determined not to be presumptively eligible; or

(b) Determined to be presumptively eligible but fails to file an application for Medicaid with the DCBS before the individual's[her] presumptive eligibility ends and therefore is determined to be ineligible for Medicaid benefits.

(2) The appeal rights of the Medicaid Program shall apply if an individual[a woman] is:

(a) Determined to be presumptively eligible; and

(b) Files an application with the DCBS but is determined ineligible for Medicaid benefits.

(3) Except as specified in subsection (1) of this section, an appeal of a negative action taken by the department regarding a Medicaid recipient shall be in accordance with:

(a) 907 KAR 1:563 if the individual is:

1. Not enrolled with a managed care organization; or

2. Enrolled with a managed care organization and the individual has exhausted the MCO internal appeal process in accordance with 907 KAR 17:010 and requests an appeal of an adverse decision by the MCO; or

(b) 907 KAR 17:010 if the individual is enrolled with a managed care organization.

(4) Except as specified in subsection (1) of this section, an

appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(5) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.

Section 7.[8.] Quality Assurance and Utilization Review. The cabinet shall evaluate, on a continuing basis, access, continuity of care, health outcomes, and services arranged or provided by a Medicaid provider to a presumptively eligible individual[presumed eligible woman] in accordance with accepted standards of practice for medical service.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2104

FILED WITH LRC: January 14, 2014 at 1 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes Medicaid eligibility provisions regarding presumptive eligibility. Presumptive eligibility is a program designed to improve pregnant women's access to outpatient prenatal care. Providers authorized to make presumptive eligibility determinations complete an application to determine whether a given pregnant woman qualifies for Medicaid under this program. If the provider determines that the woman is eligible, the provider will be reimbursed for prenatal services provided to the woman.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid eligibility provisions regarding presumptive eligibility.

(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 eligibility provisions regarding presumptive eligibility.

(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 Medicaid eligibility provisions regarding presumptive eligibility.

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

(a) How the amendment will change this existing administrative regulation: The amendment to this administrative regulation authorizes inpatient hospitals to make presumptive eligibility determinations for all individuals for whom a modified adjusted gross income is the Medicaid income eligibility standard and deletes the definitions. Hospitals are not required to make presumptive eligibility determinations, but will be authorized to do so. The provider types who were previously authorized to make presumptive eligibility determinations regarding pregnant women will continue to be authorized to do so, but not for all individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard. The amendment after comments clarifies that the presumptive eligibility income threshold for pregnant women is 195 percent of the federal poverty level rather than 185 percent of the federal poverty level; corrects the presumptive eligibility period; and replaces a description of individuals whose eligibility is a modified adjusted gross income (MAGI) standard with a reference to the MAGI administrative regulation.

(b) The necessity of the amendment to this administrative regulation: Authorizing inpatient hospitals to make presumptive eligibility determinations for all individuals for whom a modified adjusted gross income is in the Medicaid income eligibility standard is necessary to comply with an Affordable Care Act mandate. Deleting the definitions is necessary as the Department for

Medicaid Services (DMS) is creating a definitions administrative regulation for Chapter 20 – the new chapter which will house all Medicaid eligibility administrative regulations. The amendment after comments is necessary to clarify the presumptive eligibility income threshold for pregnant women; to correct the presumptive eligibility period; and to synchronize language among administrative regulations by referring to a relevant administrative regulation rather than duplicating language in this administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the Affordable Care Act by establishing that inpatient hospitals will be authorized to make presumptive eligibility determinations. The amendment after comments conforms to the content of the authorizing statutes by clarifying the presumptive eligibility income threshold for pregnant women; by correcting the presumptive eligibility period; and by synchronizing language among administrative regulations by referring to a relevant administrative regulation rather than duplicating language in this administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the Affordable Care Act by establishing that inpatient hospitals will be authorized to make presumptive eligibility determinations. The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying the presumptive eligibility income threshold for pregnant women; by correcting the presumptive eligibility period; and by synchronizing language among administrative regulations by referring to a relevant administrative regulation rather than duplicating language in this administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All inpatient hospitals participating in Kentucky's Medicaid program will be authorized to make presumptive eligibility decisions for individuals whose Medicaid eligibility standard is a modified adjusted gross income (MAGI) but are not required to do so. Medicaid recipients who may gain presumptive eligibility coverage as a result of an inpatient hospital's determination will be affected. Currently, there are over 100 inpatient hospitals participating in Kentucky's Medicaid program. The Department for Medicaid Services (DMS) estimates that over 500,000 individuals could be eligible for Medicaid under the modified adjusted gross income (MAGI) rules in state fiscal year 2014.

(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. Inpatient hospitals who wish to make presumptive eligibility determinations will have to complete the required application for each applicant to determine if the individual qualifies via the presumptive eligibility option.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Inpatient hospitals will benefit by making determinations and being reimbursed for services provided to individuals for whom the hospital determined is eligible via the presumptive eligibility option. Individuals determined to be presumptive eligible by an inpatient hospital will benefit by receiving Medicaid-covered services during the presumptive eligibility period. Additionally, individuals will hopefully be prompted, as a result of receiving presumptive eligibility for Medicaid benefits, to apply for "standard" Medicaid coverage (before their presumptive eligibility period ends) and remain eligible for Medicaid benefits.

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

(a) Initially: The Department for Medicaid Services (DMS) is

unable to estimate how many individuals could be determined to be presumptively eligible by inpatient hospitals or to predict how many hospitals will choose to make presumptive eligibility determinations. DMS projects that over 500,000 individuals will be in the eligibility group (the MAGI group) which could be made presumptively eligible by inpatient hospitals; however, the same individuals can gain eligibility without being admitted to an inpatient hospital. As it's difficult to predict how hospitals will make presumptive eligibility determinations and how many individuals will gain Medicaid eligibility as a result of a presumptive eligibility determination, it is difficult to estimate costs associated with inpatient hospital presumptive eligibility determinations.

(b) On a continuing basis: The answer in paragraph (a) also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under Title XIX of the Social Security Act and state general 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: Neither an increase in fees nor funding 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 directly nor indirectly establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is applied in the sense that inpatient hospitals can only make presumptive eligibility determinations for those whose Medicaid eligibility standard is a modified adjusted gross income (MAGI). The Affordable Care Act authorizes hospitals to make such determinations for only the MAGI population.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. The presumptive eligibility option is not mandatory. The requirements regarding the program, for states who choose to offer it, are established in 42 U.S.C. 1396f-1, 42 U.S.C. 1396a(a)(47), and 42 U.S.C. 1396b(u)(1)(D)(v).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet 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.

3. Minimum or uniform standards contained in the federal mandate. The presumptive eligibility option is not federally mandated; however, if a state chooses to offer it the following requirements apply: 42 U.S.C. 1396a(a)(47) establishes that any hospital participating in the Medicaid program may "elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period..." 42 U.S.C. 1396b(u)(1)(D)(v) establishes that the federal government (Centers for Medicare and Medicaid Services) will not consider federal Medicaid funds spent on services to an individual who was erroneously determined to be presumptively eligible by a hospital (that chose to make presumptive eligibility determinations) to be an "erroneous excess payment for medical assistance" (i.e. an erroneous excess Medicaid expenditure.) The result of the policy is that CMS will not seek to recover such expenditure from the given state. "42 U.S.C. 1396b(u)(1)(D)(v) – Limitation of Federal Financial Participation in Erroneous Medicaid Assistance Expenditures

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, for medical assistance provided to an individual described in

subsection (a) of section 1920B during a presumptive eligibility period under such section, or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose." 42 U.S.C. 1396r-1 defines the presumptive eligibility period for a pregnant woman and providers qualified to render presumptive eligibility determinations. It defines the presumptive eligibility period as follows: "(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan, or

(ii) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination referred to in subparagraph (A), such last day."

It defines qualified provider as follows:

"any provider that—

(A) is eligible for payments under a State plan approved under this title,

(B) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9),

(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

(D) (i) receives funds under—

(I) section 330 or 330A of the Public Health Service Act,

(II) title V of this Act, or

(III) title V of the Indian Health Care Improvement Act;

(ii) participates in a program established under—

(I) section 17 of the Child Nutrition Act of 1966, or

(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973;

(iii) participates in a State perinatal program; or

(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).

The term 'qualified provider' also includes a qualified entity, as defined in section 1920A(b)(3)."

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. It does not impose stricter, additional, or different responsibilities or 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 the amendment to 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 Department for Medicaid Services (DMS) is unable to estimate how many individuals could be determined to be presumptively eligible by inpatient hospitals or to predict how many hospitals will choose to make presumptive eligibility determinations. DMS projects that over 500,000 individuals will be in the eligibility group (the MAGI group) which could be made presumptively eligible by inpatient hospitals; however, the same individuals can gain eligibility without being admitted to an inpatient hospital. As it's difficult to predict how hospitals will make presumptive eligibility determinations and how many individuals will gain Medicaid eligibility as a result of a presumptive eligibility determination, it is difficult to estimate revenues associated with inpatient hospital presumptive eligibility determinations.

(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 answer in paragraph (a) also applies here.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) is unable to estimate how many individuals could be determined to be presumptively eligible by inpatient hospitals or to predict how many hospitals will choose to make presumptive eligibility determinations. DMS projects that over 500,000 individuals will be in the eligibility group (the MAGI group) which could be made presumptively eligible by inpatient hospitals; however, the same individuals can gain eligibility without being admitted to an inpatient hospital. As it's difficult to predict how hospitals will make presumptive eligibility determinations and how many individuals will gain Medicaid eligibility as a result of a presumptive eligibility determination, it is difficult to estimate costs associated with inpatient hospital presumptive eligibility determinations.

(d) How much will it cost to administer this program for subsequent years? The answer in paragraph (c) also applies here.

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 Policy and Operations (Amended After Comments)

907 KAR 20:060. Medicaid adverse action and conditions for recipients.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 431.210, 431.211, 431.213, 431.214, 42 U.S.C. 1396a, b, d[-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) empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds [for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes [sets forth] the conditions under which an application is denied or medical assistance is decreased or discontinued and advance notice requirements.

Section 1. [Definitions. (1) "Applicant" means an individual applying for Medicaid.

(2) "Application" means the process set forth in 907 KAR 1:640.

(3) "Medicaid coverage" means items or services a Medicaid recipient may receive

through the Medicaid Program.

(4) "Recipient" means an individual who receives Medicaid.

Section 2.] Reasons for Adverse Action. (1) For an individual:

(a) Whose eligibility standard is not a modified adjusted gross income, an application for Medicaid eligibility shall be denied if:

1. The individual's (a) income exceeds[or resources exceed] the standards as established in 907 KAR 20:020[set forth in 907 KAR 1:004];

2. The individual's resources exceed the standard established in 907 KAR 20:025;

3. [(b)] The applicant does not meet technical eligibility criteria or fails to comply with a technical requirement as established in 907 KAR 20:005[set forth in 907 KAR 1:011];

4. [(e)] Despite receipt of written notice detailing the additional information needed for a determination, the applicant fails to provide sufficient information or clarify conflicting information necessary for a determination of eligibility;

5. [(d)] The applicant fails to keep the appointment for an interview without good cause;

6. [(e)] The applicant requests, in writing, voluntary withdrawal of the application without good cause;

7. [(f)] Staff are unable to locate the applicant; or

8. [(g)] The applicant is no longer domiciled in Kentucky;

(b) Whose eligibility standard is a modified adjusted gross income pursuant to 907 KAR 20:100, the application for Medicaid eligibility shall be denied if:

1. Income exceeds the standards as established in 907 KAR 20:100;

2. The applicant does not meet the citizenship, residency, and other technical requirements established in 907 KAR 20:100;

3. Despite receipt of written notice detailing the additional information needed for a determination, the applicant fails to provide sufficient information or clarify conflicting information necessary for a determination of eligibility;

4. The applicant fails to keep the appointment for an interview without good cause;

5. The applicant requests, in writing, voluntary withdrawal of the application without good cause;

6. Staff are unable to locate the applicant; or

7. The applicant is no longer domiciled in Kentucky; or

(c) Who is a former foster care individual between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage, an application for Medicaid shall be denied if:

1. The applicant does not meet the citizenship, residency, and other technical requirements established in 907 KAR 20:075;

2. Despite receipt of written notice detailing the additional information needed for a determination, the applicant fails to provide sufficient information or clarify conflicting information necessary for a determination of eligibility;

3. The applicant fails to keep the appointment for an interview without good cause;

4. The applicant requests, in writing, voluntary withdrawal of the application without good cause;

5. Staff are unable to locate the applicant; or

6. The applicant is no longer domiciled in Kentucky.

(2) Medicaid eligibility shall be discontinued;

(a) For a recipient whose Medicaid eligibility income standard is not a modified adjusted gross income if:

1. [(a)] Income[or resources] of the recipient exceeds[exceed] the standards established in 907 KAR 20:020[set forth in 907 KAR 1:004];

2. Resources of the recipient exceed the standard established in 907 KAR 20:025;

3. [(b)] Deductions decrease[decrease] resulting in income exceeding the standards established in 907 KAR 20:020[set forth in 907 KAR 1:004];

4. [(e)] The recipient does not meet technical eligibility criteria or fails to comply with a technical requirement as established in 907 KAR 20:005[set forth in 907 KAR 1:011];

5. [(d)] Despite receipt of written notice detailing the additional information needed for a redetermination, the recipient fails to provide sufficient information or clarify conflicting information

necessary for a redetermination of eligibility;

6. [(e)] The recipient fails to keep the appointment for an interview;

7. [(f)] Staff are unable to locate the recipient;

8. [(g)] The recipient is no longer domiciled in Kentucky; or

9. [(h)] A change in program policy that adversely affects the recipient has occurred;

(b) For a recipient whose Medicaid eligibility income standard is a modified adjusted gross income if:

1. Income of the recipient exceeds the standards established in 907 KAR 20:100;

2. The applicant does not meet the citizenship, residency, and other technical requirements established in 907 KAR 20:100;

3. Despite receipt of written notice detailing the additional information needed for a redetermination, the recipient fails to provide sufficient information or clarify conflicting information necessary for a redetermination of eligibility;

4. The recipient fails to keep the appointment for an interview;

5. Staff are unable to locate the recipient;

6. The recipient is no longer domiciled in Kentucky; or

7. A change in program policy that adversely affects the recipient has occurred;

(c) For a former foster care individual between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage if:

1. The applicant does not meet the citizenship, residency, and other technical requirements established in 907 KAR 20:075;

2. Despite receipt of written notice detailing the additional information needed for a redetermination, the recipient fails to provide sufficient information or clarify conflicting information necessary for a redetermination of eligibility;

3. The recipient fails to keep the appointment for an interview;

4. Staff are unable to locate the recipient;

5. The recipient is no longer domiciled in Kentucky; or

6. A change in program policy that adversely affects the recipient has occurred.

(3) Patient liability shall be increased if:

(a) Income of the recipient increases; or

(b) Deductions decrease.

(4) Medicaid eligibility may be redetermined in another category resulting in a reduction of Medicaid coverage for an individual whose income eligibility standard is:

(a) Not a modified adjusted gross income, if:

1. [(a)] Income exceeds[or resources exceed] the standards established[as set forth] in 907 KAR 20:020[1:004]; or

2. The individual[(b) The recipient] does not meet technical eligibility requirements established in 907 KAR 20:005; or

(b) A modified adjusted gross income, if:

1. Income exceeds the standards established in 907 KAR 20:100; or

2. The individual does not meet the citizenship, residency, and other technical eligibility requirements established in 907 KAR 20:100[as set forth in 907 KAR 1:011].

(5) Medicaid coverage may be reduced due to a change in Medicaid coverage policy.

Section 2.[3.] Notification of Denial of Applications. If a Medicaid application is denied, the applicant shall be given written notification of the denial which shall include:

(1) The reason for the denial;

(2) The cites of the applicable state administrative regulation; and

(3) The right to an administrative[a fair] hearing as established in 907 KAR 20:065[set forth in 907 KAR 1:560].

Section 3.[4.] Advance Notice of a Discontinuance, Increase in Patient Liability, or a Reduction of Medicaid Coverage. (1) A[The] recipient shall be given ten (10) days advance notice of the proposed action if a change in circumstances indicates:

(a) A discontinuance of Medicaid coverage;

(b) An increase in patient liability; or

(c) A reduction of Medicaid coverage.

(2) A[The] recipient shall be given five (5) days advance notice

of the proposed action if a change in circumstance indicates:

(a) Facts that action should be taken because of probable fraud by the recipient; and

(b) The facts have been verified through secondary sources.

(3) The ten (10) days advance notice and the five (5) days advance notice of proposed action shall:

(a) Be in writing;

(b) Explain the reason for the proposed action;

(c) Cite the applicable state administrative regulation;

(d) Explain the individual's right to request an administrative[a fair] hearing;

(e) Provide an explanation of the circumstances under which Medicaid is continued if an administrative[a] hearing is requested; and

(f) Include that the applicant or recipient may be represented by an attorney or other party if the applicant or recipient[he] so desires.

(4) An administrative[A] hearing request received during the advance notice period may result in a delay of the discontinuance of Medicaid coverage, a delay in an increase in patient liability, or delay of a reduction of Medicaid coverage pending the hearing officer's decision, as established in 907 KAR 20:065[set forth in 907 KAR 1:560].

Section 4.[5.] Exceptions to the Advance Notice Requirement. An advance notice of proposed action shall not be required, but written notice of action taken shall be given, if discontinuance of Medicaid coverage or an increase in patient liability resulted from:

(1) Information reported by the recipient if the recipient signs a waiver of the notice requirement indicating understanding of the consequences;

(2) A clear written statement, signed by the recipient, that the recipient[he] no longer wishes to receive Medicaid;

(3) Factual information is received that the recipient has died;

(4) Whereabouts of the recipient are unknown and mail addressed to the recipient[him] is returned indicating no known forwarding address;

(5) Establishment by the agency that Medicaid has been accepted in another state;

(6) The recipient enters:

(a) A penal institution; or

(b) If between twenty-one (21) and sixty-five (65) years of age, a mental hospital or an institution for mental disease (IMD); or

(7) A change in the level of medical care is prescribed by the recipient's physician.

Section 5. Expiration of Hospital or Psychiatric Residential Treatment Facility Stay.[6.] Expiration of an approved time-limited hospital or psychiatric residential treatment facility stay shall not constitute a termination, suspension, or reduction of benefits.

Section 6. Individuals Whose Income Eligibility Standard is a Modified Adjusted Gross Income. An individual whose Medicaid eligibility is determined using a modified adjusted gross income as the eligibility standard shall be as established in 907 KAR 20:100[an individual who is:

(1) A child under the age of nineteen (19) years, excluding children in foster care;

(2) A caretaker relative with income up to 133 percent of the federal poverty level;

(3) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

(4) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

(a) Does not have a dependent child under the age of nineteen (19) years; and

(b) Is not otherwise eligible for Medicaid benefits; or

(5) A targeted low income child with income up to 150 percent of the federal poverty level][7. Material Incorporated by Reference. (1) The forms necessary for adverse action in the Medicaid Program are being incorporated effective April 1, 1995. These forms include the MA 105, revised July 1992 and the KIM

105, revised September 1992.

(2) material incorporated by reference may be reviewed at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621. Office hours are 8 a.m. to 4:30 p.m. Copies may be obtained from that office upon payment of the appropriate fee allowed by 200 KAR 1:020].

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 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.

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 the conditions under which an application for Medicaid is denied, medical assistance is decreased or discontinued, and related advance notice requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program conditions and requirements addressed in paragraph (a) in accordance with federal law and regulation and as authorized by KRS 194A.030(2) which establishes the Department for Medicaid Services as the commonwealth's single state agency for administering the federal Social Security Act.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing the Medicaid program conditions and requirements addressed in paragraph (a).

(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 KRS 194A.030(2), 194A.050(1) and 205.520(3) by establishing the Medicaid program conditions and requirements addressed in paragraph (a).

(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 establishes adverse action and notice requirements for individuals for whom the Medicaid income eligibility standard is a modified adjusted gross income (or MAGI) and for former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. These are two (2) new eligibility categories created by the Affordable Care Act and having eligibility requirements differing from the old/existing Medicaid eligibility rules. The MAGI group includes individuals previously eligible under the old rules but there is no resource standard for these individuals and their income is determined in a more simplified way under the new rules. The MAGI group also includes what is known as the expansion group which is a new eligibility group comprised of childless adults who do not otherwise qualify for Medicaid and have income up to 133 percent of the federal poverty level. The MAGI group in entirety is comprised of children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. Another new group – a group which is mandated by the Affordable Care Act – is comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. There is no income standard or resource standard for this group. The amendment also

removes definitions from the administrative regulation as those are now being established in a definitions administrative regulation for all administrative regulations within the new chapter – Chapter 20 – which will house Medicaid eligibility administrative regulations; deletes incorporated material not used by the Department for Medicaid Services; and also includes language and formatting revisions to comply with KRS Chapter 13A requirements. The amendment after comments rewords the section which establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulation.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to comply with an Affordable Care Act mandate which requires eligibility standards for the MAGI group and for former foster care individuals which differ from the eligibility standards for those who remain under the old/existing Medicaid eligibility rules. Deleting the incorporated material is necessary as the Department for Medicaid Services (DMS) does not use the material. Deleting the definitions is necessary as DMS is creating a definitions administrative regulation for Chapter 20. Additionally, language and formatting amendments are necessary to ensure conformity with the requirements established in KRS Chapter 13A. The amendment after comments is necessary to add clarity.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with Affordable Care Act mandates. The amendment after comments conforms to the content of the authorizing statutes by adding clarity.

(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 complying with Affordable Care Act mandates. The amendment after comments will assist in the effective administration of the authorizing statutes by adding clarity.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 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) 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 amendment imposes no action to be taken by the affected individuals.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment imposes no cost on the affected individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals will be able to appeal adverse actions as prescribed in this administrative regulation.

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

(a) Initially: DMS anticipates no cost as a result of the amendment.

(b) On a continuing basis: The answer provided in paragraph (a) also applies here.

(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 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 will be necessary to implement the amendment to this administrative regulation.

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

(9) Tiering: Is tiering applied? Tiering is only applied in that a different requirements apply to the MAGI group and to the former foster care individuals as mandated by the Affordable Care Act.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14) and 42 U.S.C. 1396a(a)(10)(i)(IX).

2. State compliance standards. KRS 205.520(3) states, "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. Effective January 1, 2014, each state's Medicaid program is required – except for certain designated populations - to determine Medicaid eligibility by using the modified adjusted gross income and is prohibited from using any type of expense, income disregard, or any asset or resource test. The populations exempted from the new requirements (and to whom the old requirements continue to apply) include aged individuals [individuals over sixty-five (65) years of age or who receive Social Security Disability Insurance; individuals eligible for Medicaid as a result of being a child in foster care; individuals who are blind or disabled; individuals who are eligible for Medicaid via another program; individuals enrolled in a Medicare savings program; and medically needy individuals. Additionally, states are prohibited from continuing to use income disregards, asset tests, or resource tests for individuals who are eligible via the modified adjusted gross income standard. Federal law also prohibits the application of an income standard or resource standard, for eligibility purposes, to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The amendment neither imposes stricter nor additional nor different responsibilities nor requirements than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment 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 (DMS) will be impacted by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This 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 anticipates no revenue being generated for the first year for state or local government due to the amendments.

(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 being generated for subsequent years for state or local government due to the amendments.

(c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year for state or local government due to the amendments.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years for state or local government due to the amendments.

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 Policy and Operations

(Amended After Comments)

907 KAR 20:075. Eligibility provisions and requirements regarding former foster care individuals.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

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 Medicaid eligibility provisions and requirements for an individual between the ages of nineteen (19) and twenty-six (26) years, who formerly was in foster care and was receiving Medicaid benefits at the time that the individual aged out of foster care.

Section 1. Former Foster Care Eligibility Criteria. An individual between the ages of nineteen (19) and twenty-six (26) years, who formerly was in foster care, and was receiving Medicaid benefits at the time the individual's age exceeded the foster care age limit shall be eligible for Medicaid benefits if the individual meets the requirements of this administrative regulation.

Section 2. Income Standard. There shall be no income standard for individuals between the ages of nineteen (19) and twenty-six (26) years and who formerly were in foster care but aged out of foster care.

Section 3. Resource Standard. There shall be no resource standard for individuals between the ages of nineteen (19) and twenty-six (26) years and who formerly were in foster care but aged out of foster care.

Section 4. Attestation of Having Aged Out of Foster Care. (1) An individual between the ages of nineteen (19) and twenty-six (26) years, who formerly was in foster care, and was receiving Medicaid benefits at the time the individual's age exceeded the foster care age limit shall attest, during the application process, that the individual was receiving Medicaid benefits at the time that the individual reached the age which exceeds the foster care age limit.

(2) An individual who does not attest as established in subsection (1) of this section shall not be eligible for Medicaid benefits.

Section 5. Citizenship and Residency Requirements. (1) The citizenship requirements established in 42 C.F.R. 435.406 shall apply.

~~(2)[Except as established in subsection (3) or (4) of this section.]~~ To satisfy the Medicaid:

(a) Citizenship requirements, an applicant or recipient shall be:

1. A citizen of the United States as verified through satisfactory documentary evidence of citizenship or nationality presented during initial application or if a current recipient, upon next redetermination of continued eligibility;

~~2.[Except as provided in subsection (3) of this section.]~~ A qualified alien who entered the United States before August 22, 1996, and is:

a. Lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101;

b. Granted asylum pursuant to 8 U.S.C. 1158;

c. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

d. Paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) for a period of at least one (1) year;

e. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h), as in effect prior to April 1, 1997, or 8 U.S.C. 1231(b)(3);

f. Granted conditional entry pursuant to 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

g. An alien who is granted status as a Cuban and Haitian entrant pursuant to 8 U.S.C. 1522;

h. A battered alien pursuant to 8 U.S.C. 1641(c);

i. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

j. On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

k. The spouse or unmarried dependent child of an individual described in clause i. or j. of this subparagraph or the unmarried surviving spouse of an individual described in clause i. or j. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304; or

l. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

3. A qualified alien who entered the United States on or after August 22, 1996 and is:

a. Granted asylum pursuant to 8 U.S.C. 1158;

b. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

c. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h) as in effect prior to April 1, 1997 or 8 U.S.C. 1231(b)(3);

d. An alien who is granted status as a Cuban and Haitian entrant pursuant to 8 U.S.C. 1522;

e. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

f. On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

g. The spouse or unmarried dependent child of an individual described in clause e. or f. of this subparagraph or the unmarried surviving spouse of an individual described in clause e. or f. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304;

h. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

i. An individual lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101 who has earned forty (40) quarters of Social Security coverage; and

(b) Residency requirements, the applicant or recipient shall be a resident of Kentucky who meets the conditions for determining state residency pursuant to 42 C.F.R. 435.403. ~~[(3) A qualified or nonqualified alien shall be eligible for medical assistance as provided in this subsection.]~~

(a) The individual shall meet the income, resource, and categorical requirements of the Medicaid Program.

(b) The individual shall have, or have had within at least one (1) of the three (3) months prior to the month of application, an emergency medical condition:

1. Not related to an organ transplant procedure;

2. Which shall be a medical condition, including severe pain, in which the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(c)1. Approval of eligibility shall be for a time limited period which includes, except as established in subparagraph 2 of this paragraph, the month in which the medical emergency began and the next following month.

2. The eligibility period shall be extended for an appropriate period of time upon presentation to the department of written documentation from the medical provider that the medical emergency will exist for a more extended period of time than is allowed for in the time limited eligibility period.

(d) The Medicaid benefits to which the individual is entitled shall be limited to the medical care and services, including limited follow-up, necessary for the treatment of the emergency medical condition of the individual.

(4)(a) The satisfactory documentary evidence of citizenship or nationality requirement in subsection (2)(a)1 of this section shall not apply to an individual who:

1. Is receiving SSI benefits;

2. Previously received SSI benefits but is no longer receiving them;

3. Is entitled to or enrolled in any part of Medicare;

4. Previously received Medicare benefits but is no longer receiving them;

5. Is receiving:

a. Disability insurance benefits under 42 U.S.C. 423; or

b. Monthly benefits under 42 U.S.C. 402 based on the individual's disability pursuant to 42 U.S.C. 223(d);

6. Is in foster care and who is assisted under Title IV-B of the Social Security Act; or

7. Receives foster care maintenance or adoption assistance payments under Title IV-E of the Social Security Act.

(b) The department's documentation requirements shall be in accordance with the requirements established in 42 U.S.C. 1396b(x).

(5) The department shall assist an applicant or recipient who is unable to secure satisfactory documentary evidence of citizenship or nationality in a timely manner because of incapacity of mind or body and lack of a representative to act on the applicant's or recipient's behalf.

(6)(a) Except as established in paragraph (b) of this subsection, an individual shall be determined eligible for Medicaid for up to three (3) months prior to the month of application if all conditions of eligibility are met.

(b) The retroactive eligibility period shall begin no earlier than January 1, 2014 for an individual who gains Medicaid eligibility solely by qualifying:

1. As a former foster care individual pursuant to this administrative regulation; or

2. As an adult with income up to 133 percent of the federal poverty level who:

a. Does not have a dependent child under the age of nineteen (19) years; and

b. Is not otherwise eligible for Medicaid benefits.]

Section 6. Provision of Social Security Numbers. (1)[(a)] Except as provided in subsections (2) and (3) of this section, an applicant for or recipient of Medicaid shall provide a Social Security number as a condition of eligibility. [(b) If a parent or caretaker relative and the child, unless the child is a deemed eligible newborn, refuses to cooperate with obtaining a Social

Security number for the newborn child or other dependent child, the parent or caretaker relative shall be ineligible due to failing to meet technical eligibility requirements.]

(2) An individual shall not be denied eligibility or discontinued from eligibility due to a delay in receipt of a Social Security number from the United States Social Security Administration if appropriate application for the number has been made.

(3) An individual who refuses to obtain a Social Security number due to a well-established religious objection shall not be required to provide a Social Security number as a condition of eligibility.

Section 7. Institutional Status. (1) An individual shall not be eligible for Medicaid if the individual is a:

(a) Resident or inmate of a nonmedical public institution except as established in subsection (2) of this section;

(b) Patient in a state tuberculosis hospital unless the individual[he] has reached age sixty-five (65);

(c) Patient in a mental hospital or psychiatric facility unless the individual is:

1. Under age twenty-one (21) years of age; or

2. Under age twenty-two (22) if the individual was receiving inpatient services on his or her 21st birthday; or 3. Sixty-five (65) years of age or over; or

(d) Patient in a nursing facility classified by the Medicaid program as an institution for mental diseases, unless the individual has reached age sixty-five (65)].

(2) An inmate who meets the eligibility criteria in this administrative regulation shall[may] be eligible for Medicaid after having been admitted to a medical institution and been an inpatient at the institution for at least twenty-four (24) consecutive hours.

Section 8. [Incarceration Status. An inmate who meets the eligibility requirements of this administrative regulation shall be eligible for Medicaid after having been admitted to a medical institution and been an inpatient at the institution for at least twenty-four (24) consecutive hours.

Section 9. Application for Other Benefits. (1)(a) As a condition of eligibility for Medicaid, an applicant or recipient shall apply for each annuity, pension, retirement, and disability benefit to which the individual is entitled, unless the individual can demonstrate good cause for not doing so.

(b) Good cause shall be considered to exist if other benefits have previously been denied with no change of circumstances or the individual does not meet all eligibility conditions.

(c) Annuities, pensions, retirement, and disability benefits shall include:

1. Veterans' compensations and pensions;

2. Retirement, Survivors, and Disability Insurance;

3. Railroad retirement benefits;

4. Unemployment compensation; and

5. Individual retirement accounts.

(2) An applicant or recipient shall not be required to apply for federal benefits if:

(a) The federal law governing that benefit specifies that the benefit is optional; and

(b) The applicant or recipient believes that applying for the benefit would be to the applicant's or recipient's disadvantage.

(3) An individual who would be eligible for SSI benefits but has not applied for the benefits shall not be eligible for Medicaid.

Section 10. Assignment of Rights to Medical Support. By accepting assistance for or on behalf of a child, a recipient shall be deemed to have assigned to the Cabinet for Health and Family Services any medical support owed for the child not to exceed the amount of Medicaid payments made on behalf of the recipient.

Section 11. Third-party Liability as a Condition of

Eligibility. ~~(1)(a) Except as provided in subsection (3) of this section, an individual applying for or receiving Medicaid shall be required as a condition of eligibility to cooperate with the Cabinet for Health and Family Services in identifying, and providing information to assist the cabinet in pursuing, any third party who may be liable to pay for care or services available under the Medicaid program unless the individual has good cause for refusing to cooperate.~~

~~(b) Good cause for failing to cooperate shall exist if cooperation:~~

~~1. Could result in physical or emotional harm of a serious nature to a child or custodial parent;~~

~~2. Is not in a child's best interest because the child was conceived as a result of rape or incest; or~~

~~3. May interfere with adoption considerations or proceedings.~~

~~(2) A failure of an individual to cooperate without good cause shall result in ineligibility of the individual.~~

~~(3) A pregnant woman eligible under poverty level standards shall not be required to cooperate in establishing paternity or securing support for her unborn child.~~

Section 12.] Application Process, Initial and Continuing Eligibility Determination. (1) An individual may apply for Medicaid benefits by:

(a) Using the Web site located at www.kynect.ky.gov;

(b) Applying over the telephone by calling:

1. 1-855- 459-6328; or

2. 1-855-326-4654 if deaf or hearing impaired;

(c) Faxing an application to 1-502-573-2007;

(d) Mailing a paper application to Office of Health Benefits Exchange, 12 Mill Creek, Frankfort, Kentucky[,] 40601; or

(e) Going to the applicant's local Department for Community Based Services Office and applying in person.

(2) An individual shall attest in accordance with Section 4 of this administrative regulation when applying for Medicaid benefits.

(3)(a) An application shall be processed (approved, denied, or a request for additional information sent) by the department or other entity involved in processing the given application within forty-five (45) days of application submittal.

(b) If a trusted source indicates that an applicant is incarcerated, a request for additional information shall be generated by the department or other entity involved in processing the application requesting verification of the applicant's incarceration dates or status.

(c) If an applicant fails to provide information in response to a request for additional information within forty-five (45) days of the beginning of the application process, the application shall be denied. ~~[(4)(a) An annual renewal of eligibility shall occur without an individual having to take action to renew eligibility, unless:~~

~~1. The individual's eligibility circumstances change resulting in the individual no longer being eligible for Medicaid; or~~

~~2. A request for additional information is generated due to a change in income or incarceration status.~~

~~(b)1. If an individual receives a request for additional information as part of the renewal process, the individual shall provide the information requested within forty-five (45) days of receiving the request.~~

~~2. If an individual fails to provide the information requested within forty-five (45) days of receiving the request, the individual's eligibility shall be terminated on the forty-fifth day from the request for additional information.~~

~~(5) An individual shall be required to report to the department any changes in circumstances or information related to Medicaid eligibility.]~~

Section 9.[13.] Adverse Action, Notice, and Appeals. The adverse action, notice, and appeals provisions established in 907 KAR 20:060 shall apply to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. **[Section 14.]**

Implementation Date of Former Foster Care Eligibility Provisions and Requirements.

~~(1) The eligibility provisions and requirements established in this administrative regulation shall be effective beginning on January 1, 2014.~~

~~(2) An individual shall not be eligible to receive Medicaid benefits pursuant to the eligibility provisions and requirements established in this administrative regulation any earlier than January 1, 2014.]~~

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the provisions and requirements regarding Medicaid eligibility for a new eligibility group mandated by the Affordable Care Act. The new group is comprised of individuals between the ages of nineteen (19) and twenty-six (26) who formerly were in foster care and aged out of foster care while receiving Medicaid coverage at the time of aging out of foster care. To qualify for Medicaid coverage the individuals have to attest to having received Medicaid benefits at the time they aged out of foster care but there is no income standard or resource standard/test for this population as the Affordable Care Act prohibits such standards from being applied to this population. Additionally, the individuals have to meet residency and citizenship requirements that other Medicaid applicants/recipients have to meet.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with an Affordable Care Act mandate to establish Medicaid eligibility for a new eligibility group comprised of individuals between the ages of nineteen (19) and twenty-six (26) who formerly were in foster care and aged out of foster care while receiving Medicaid benefits at the time of aging out of foster care.

(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 eligibility requirements for a new Medicaid eligibility group mandated by the Affordable Care Act.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the eligibility requirements for a new Medicaid eligibility group mandated by the Affordable Care Act.

(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 after comments deletes provisions that do not apply to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while still covered under Medicaid.

(b) The necessity of the amendment to this administrative regulation: The amendment after comments is necessary to delete provisions that do not apply to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while still covered under Medicaid.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment after comments conforms to the content of the authorizing statutes by deleting provisions that do not apply to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while still covered under Medicaid.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments will assist in the effective administration of the authorizing statutes by deleting provisions that do not apply to former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while still covered under Medicaid.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals in the newly mandated eligibility category [individuals aged nineteen (19) to twenty-six (26) who formerly were in foster care but aged out of foster care] are affected. Currently, there are 700 foster care individuals for whom the Department for Community Based Services (DCBS) purchases health insurance, but the Department for Medicaid Services (DMS) estimates that over 3,300 individuals will become eligible for Medicaid coverage as a result of this new eligibility group.

(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. Individuals would need to apply for Medicaid coverage in order to gain Medicaid coverage.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). This amendment imposes no cost on the regulated individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals in the new mandated Medicaid eligibility group – individuals aged nineteen (19) to twenty-six (26) who previously were in foster care but aged out of foster care – will benefit by becoming eligible for Medicaid benefits.

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

(a) Initially: Adding the new mandated Medicaid eligibility group - individuals aged nineteen (19) to twenty-six (26) who previously were in foster care but aged out of foster care – will enable the Department for Medicaid Services (DMS) to receive federal funding [at a seventy (70) percent match rate] for health insurance coverage for these individuals. Previously, the Department for Community Based Services (DCBS) purchased health insurance coverage for approximately 700 of these individuals with 100% state general funds. The annual cost was approximately \$1 million. Thus, covering this group via the Medicaid program is expected to reduce Cabinet for Health and Family Services' expenditures by \$700,000 annually. However, DMS estimates that over 3,300 individuals will become eligible in the next year via this eligibility category with a total cost of approximately \$42.1 million. The federal matching percent for this new eligibility group is seventy (70) percent; thus, the federal share of \$42.1 million would be \$29.47 million and the commonwealth's share would be \$12.63 million.

(b) On a continuing basis: DMS projects the cost of covering former foster care individuals estimated for the first year will remain near that level in future years.

(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 matching funds from 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. Additional funding from DMS will be needed to cover the cost of care of individuals between the ages of nineteen (19) and twenty-six (26) who were formerly in foster care but aged out of foster care.

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

(9) Tiering: Is tiering applied? Tiering is not applied as the

requirements apply equally to all individuals in the new eligibility group.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

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) authorizes the Cabinet for Health and Family Services 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."

3. Minimum or uniform standards contained in the federal mandate. Federal law created the new mandated eligibility category of individuals between nineteen (19) and twenty-six (26) who formerly were in foster care but aged out of foster care and were receiving Medicaid benefits at the time of aging out of foster care and bars the application of an income standard or resource/asset test or standard to this population.

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 (DMS), the Department for Community Based Services (DCBS), and Department of Corrections will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 435.603 and this administrative regulation authorize the action taken by this administrative regulation.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS anticipates no revenue being generated for the first year for state or local government due to the amendment to this 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 anticipates no revenue being generated for subsequent years for state or local government due to the amendment to this administrative regulation.

(c) How much will it cost to administer this program for the first year? Adding the new mandated Medicaid eligibility group - individuals aged nineteen (19) to twenty-six (26) who previously were in foster care but aged out of foster care – will enable the Department for Medicaid Services (DMS) to receive federal funding [at a seventy (70) percent match rate] for health insurance coverage for these individuals. Previously, the Department for

Community Based Services (DCBS) purchased health insurance coverage for approximately 700 of these individuals with 100% state general funds. The annual cost was approximately \$1 million. Thus, covering this group via the Medicaid program is expected to reduce Cabinet for Health and Family Services' expenditures by \$700,000 annually. However, DMS estimates that over 3,300 individuals could become eligible in the next year via this eligibility category with a total cost of approximately \$42.1 million. The federal matching percent for this new eligibility group is seventy (70) percent; thus, the federal share of \$42.1 million would be \$29.47 million and the commonwealth's share would be \$12.63 million.

(d) How much will it cost to administer this program for subsequent years? DMS projects the cost of covering former foster care individuals estimated for the first year will remain near that level in future years.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amended After Comments)

907 KAR 20:100. Modified Adjusted Gross Income (MAGI) Medicaid eligibility standards.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(e)(14)

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 provisions and requirements for individuals whose Medicaid eligibility is determined using the modified adjusted gross income as the income standard. The affected individuals include children under the age of nineteen (19) years, pregnant women up to sixty (60) days postpartum, caretaker relatives, and adults under age sixty-five (65) who do not have a dependent child under the age of nineteen (19) years and are not otherwise eligible for Medicaid benefits.

Section 1. Applicability. (1)(a) The provisions and requirements of this administrative regulation shall apply to individuals whose Medicaid eligibility is determined using the modified adjusted gross income as the income standard.

(b) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be an individual:

1. Who is:

a. A child under the age of nineteen (19) years, excluding children in foster care;

b. A caretaker relative with income up to 133 percent of the federal poverty level;

c. A pregnant woman, with income up to ~~195~~**185** percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;

d. An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:

(i) Does not have a dependent child under the age of nineteen (19) years; and

(ii) Is not otherwise eligible for Medicaid benefits; or

e. A targeted low income child with income up to 150 percent of the federal poverty level.

(2)(a) If an eligibility determination indicates that an individual's income exceeds 133 percent of the federal poverty level, the department shall apply an additional cushion of five (5) percent of the federal poverty level toward the eligibility determination for the individual.

(b) If after the five (5) percent adjustment, the individual's income is under the adjusted income threshold, the individual shall meet the modified adjusted gross income standard.

(3) The provisions and requirements of this administrative regulation shall not apply to individuals whose Medicaid eligibility is determined using an eligibility standard that is not the modified adjusted gross income.

Section 2. MAGI-based Methods. The department shall use the MAGI-based methods established in 42 C.F.R. 435.603 to determine whether an individual meets the Medicaid income eligibility requirements when the eligibility standard is the modified adjusted gross income.

Section 3. Resources Not Considered. An individual's resources shall not be considered for the purpose of determining Medicaid eligibility when the eligibility standard is the modified adjusted gross income.

Section 4. Citizenship and Residency Requirements. (1) The citizenship requirements established in 42 C.F.R. 435.406 shall apply.

(2) Except as established in subsection (3) or (4) of this section, to satisfy the Medicaid:

(a) Citizenship requirements, an applicant or recipient shall be:

1. A citizen of the United States as verified through satisfactory documentary evidence of citizenship or nationality presented during initial application or if a current recipient, upon next redetermination of continued eligibility;

2. Except as provided in subsection (3) of this section, a qualified alien who entered the United States before August 22, 1996, and is:

a. Lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101;

b. Granted asylum pursuant to 8 U.S.C. 1158;

c. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

d. Paroled into the United States pursuant to 8 U.S.C. 1182(d)(5) for a period of at least one (1) year;

e. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h), as in effect prior to April 1, 1997, or 8 U.S.C. 1231(b)(3);

f. Granted conditional entry pursuant to 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;

g. An alien who is granted status as a Cuban and Haitian entrant pursuant to 8 U.S.C. 1522;

h. A battered alien pursuant to 8 U.S.C. 1641(c);

i. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

j. On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

k. The spouse or unmarried dependent child of an individual described in clause i. or j. of this subparagraph or the unmarried surviving spouse of an individual described in clause i. or j. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304; or

l. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

3. A qualified alien who entered the United States on or after August 22, 1996, and is:

a. Granted asylum pursuant to 8 U.S.C. 1158;

b. A refugee admitted to the United States pursuant to 8 U.S.C. 1157;

c. An alien whose deportation is being withheld pursuant to 8 U.S.C. 1253(h) as in effect prior to April 1, 1997, or 8 U.S.C. 1231(b)(3);

d. An alien who is granted status as a Cuban and Haitian entrant pursuant to 8 U.S.C. 1522;

e. A veteran pursuant to 38 U.S.C. 101, 107, 1101, or 1301 with a discharge characterized as an honorable discharge and not on account of alienage;

f. On active duty other than active duty for training in the Armed Forces of the United States and who fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d);

g. The spouse or unmarried dependent child of an individual described in clause e. or f. of this subparagraph or the unmarried surviving spouse of an individual described in clause e. or f. of this subparagraph if the marriage fulfills the requirements established in 38 U.S.C. 1304;

h. An Amerasian immigrant pursuant to 8 U.S.C. 1612(a)(2)(A)(v); or

i. An individual lawfully admitted for permanent residence pursuant to 8 U.S.C. 1101 who has earned forty (40) quarters of Social Security coverage; and

(b) Residency requirements, the applicant or recipient shall be a resident of Kentucky who meets the conditions for determining state residency pursuant to 42 C.F.R. 435.403.

(3) A qualified or nonqualified alien shall be eligible for medical assistance as provided in this subsection.

(a) The individual shall meet the income, resource, and categorical requirements of the Medicaid Program.

(b) The individual shall have, or have had within at least one (1) of the three (3) months prior to the month of application, an emergency medical condition:

1. Not related to an organ transplant procedure;

2. Which shall be a medical condition, including severe pain, in which the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(c)1. Approval of eligibility shall be for a time limited period which includes, except as established in subparagraph 2 of this paragraph, the month in which the medical emergency began and the next following month.

2. The eligibility period shall be extended for an appropriate period of time upon presentation to the department of written documentation from the medical provider that the medical emergency will exist for a more extended period of time than is allowed for in the time limited eligibility period.

(d) The Medicaid benefits to which the individual is entitled shall be limited to the medical care and services, including limited follow-up, necessary for the treatment of the emergency medical condition of the individual.

(4)(a) The satisfactory documentary evidence of citizenship or nationality requirement in subsection (2)(a)1 of this section shall not apply to an individual who:

1. Is receiving SSI benefits;

2. Previously received SSI benefits but is no longer receiving them;

3. Is entitled to or enrolled in any part of Medicare;

4. Previously received Medicare benefits but is no longer receiving them;

5. Is receiving:

a. Disability insurance benefits under 42 U.S.C. 423; or

b. Monthly benefits under 42 U.S.C. 402 based on the individual's disability pursuant to 42 U.S.C. 223(d);

6. Is in foster care and who is assisted under Title IV-B of the Social Security Act; or

7. Receives foster care maintenance or adoption assistance payments under Title IV-E of the Social Security Act.

(b) The department's documentation requirements shall be in accordance with the requirements established in 42 U.S.C. 1396b(x).

(5) The department shall assist an applicant or recipient who is unable to secure satisfactory documentary evidence of citizenship or nationality in a timely manner because of incapacity of mind or body and lack of a representative to act on the applicant's or recipient's behalf.

(6)(a) Except as established in paragraph (b) of this subsection, an individual shall be determined eligible for Medicaid for up to three (3) months prior to the month of application if all conditions of eligibility are met.

(b) The retroactive eligibility period shall begin no earlier than January 1, 2014 for an individual who gains Medicaid eligibility solely by qualifying:

1. As a former foster care individual pursuant to 907 KAR 20:075~~[this administrative regulation]~~; or

2. As an adult with income up to 133 percent of the federal poverty level who:

a. Does not have a dependent child under the age of nineteen (19) years; and

b. Is not otherwise eligible for Medicaid benefits.

(7) The documentation of citizenship requirements established in this administrative regulation shall not apply to a noncitizen under nineteen (19) years of age who is lawfully present in the United States of America.

(8) Except as established in subsection (9) of this section, a noncitizen shall be considered to be lawfully present in the United States of America if the individual:

(a) Is a qualified noncitizen;

(b) Is a noncitizen in a valid immigrant status;

(c) Is a noncitizen who has been paroled into the United States of America in accordance with 8 U.S.C. 1182(d)(5) for less than one (1) year, except for an individual:

1. Paroled for:

a. Prosecution; or

b. Deferred inspection; or

2. Pending removal proceedings;

(d) Is a noncitizen who:

1. Has been granted:

a. Temporary resident status in accordance with 8 U.S.C. 1160 or 1225a;

b. Temporary protected status in accordance with 8 U.S.C. 1254a or is an individual with a pending application for temporary protected status who has been granted employment authorization;

c. Employment authorization under 8 C.F.R. 274a.12(c);

d. Deferred action status; or

e. An administrative stay of removal under 8 C.F.R. 241;

2. Is a family unity beneficiary in accordance with Section 301 of Pub. L. 101-649 as amended;

3. Is under deferred enforced departure in accordance with a decision made by the President of the United States of America; or

4. Is a beneficiary of an approved visa petition who has a pending application for an adjustment of status;

(e) Is an individual with a pending application for asylum:

1.a. Under 8 U.S.C.;

b. For withholding of removal under 8 U.S.C. 1231; or

c. Under the Convention of Torture; and

2. Who:

a. Has been granted employment authorization; or

b. Is under the age of fourteen (14) years and has had an application pending for at least 180 days;

(f) Is an individual who has been granted withholding of removal under the Convention Against Torture;

(g) Is a child who has a pending application for special immigrant juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

(h) Is lawfully present in American Samoa under the immigration laws of American Samoa; or

(i) Is a victim of severe trafficking in persons in accordance with the Victims of Trafficking and Violence Protection Act of 2000 (Public Law 106-386, as amended in 22 U.S.C. 7105(b)).

(9) An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the categories listed in subsection (8) of this section.

Section 5. Provision of Social Security Numbers. (1)(a) Except as provided in subsections (2) and (3) of this section, an applicant for or recipient of Medicaid shall provide a Social Security number as a condition of eligibility.

(b) If a parent or caretaker relative and the child, unless the child is a deemed eligible newborn, refuses to cooperate with obtaining a Social Security number for the newborn child or other dependent child, the parent or caretaker relative shall be ineligible due to failing to meet technical eligibility requirements.

(2) An individual shall not be denied eligibility or discontinued from eligibility due to a delay in receipt of a Social Security number from the United States Social Security Administration if appropriate application for the number has been made.

(3) An individual who refuses to obtain a Social Security number due to a well-established religious objection shall not be required to provide a Social Security number as a condition of eligibility.

~~Section 6. [Spend-down. (1) An individual shall be eligible on the basis of utilizing income above 133 percent of the federal poverty level to pay for incurred medical expenses resulting in the individual's income being below 133 percent of the federal poverty level after the expenses have been deducted.~~

~~(2) The eligibility date of an individual eligible pursuant to subsection (1) of this section shall be the date on which the spend-down liability amount is met.~~

Section 7.] Institutional Status. (1) An individual shall not be eligible for Medicaid if the individual is a:

(a) Resident or inmate of a nonmedical public institution except as established in subsection (2) of this section;

(b) Patient in a state tuberculosis hospital unless he has reached age sixty-five (65);

(c) Patient in a mental hospital or psychiatric facility unless the individual is:

1. Under age twenty-one (21) years of age;

2. Under age twenty-two (22) if the individual was receiving inpatient services on his or her 21st birthday; or

3. Sixty-five (65) years of age or over; or

(d) Patient in a nursing facility classified by the Medicaid program as an institution for mental diseases, unless the individual has reached age sixty-five (65).

(2) An inmate who meets the eligibility criteria in this administrative regulation may be eligible for Medicaid after having been admitted to a medical institution and been an inpatient at the institution for at least twenty-four (24) consecutive hours.

Section 7.[8.] Incarceration Status. An inmate who meets the eligibility requirements of this administrative regulation shall be eligible for Medicaid after having been:

(1) Admitted to a medical institution; and

(2) An inpatient at the institution for at least twenty-four (24) consecutive hours.

~~Section 8.[9. Application for Other Benefits. (1)(a) As a condition of eligibility for Medicaid, an applicant or recipient shall apply for each annuity, pension, retirement, and disability benefit to which the individual is entitled, unless the individual can demonstrate good cause for not doing so.~~

~~(b) Good cause shall be considered to exist if other benefits have previously been denied with no change of circumstances or the individual does not meet all eligibility conditions.~~

~~(c) Annuities, pensions, retirement, and disability benefits shall include:~~

~~1. Veterans' compensations and pensions;~~

~~2. Retirement, Survivors, and Disability Insurance;~~

~~3. Railroad retirement benefits;~~

~~4. Unemployment compensation; and~~

~~5. Individual retirement accounts.~~

~~(2) An applicant or recipient shall not be required to apply for federal benefits if:~~

~~(a) The federal law governing that benefit specifies that the benefit is optional; and~~

~~(b) The applicant or recipient believes that applying for the benefit would be to the applicant's or recipient's disadvantage.~~

~~(3) An individual who would be eligible for SSI benefits but has not applied for the benefits shall not be eligible for Medicaid.~~

Section 10.] Assignment of Rights to Medical Support. By accepting assistance for or on behalf of a child, a recipient shall be deemed to have assigned to the Cabinet for Health and Family Services any medical support owed for the child not to exceed the amount of Medicaid payments made on behalf of the recipient.

Section 9.[11.] Third-party Liability as a Condition of Eligibility.

(1)(a) Except as provided in subsection (3) of this section, an individual applying for or receiving Medicaid shall be required as a condition of eligibility to cooperate with the Cabinet for Health and Family Services in identifying, and providing information to assist the cabinet in pursuing, any third party who may be liable to pay for care or services available under the Medicaid program unless the individual has good cause for refusing to cooperate.

(b) Good cause for failing to cooperate shall exist if cooperation:

1. Could result in physical or emotional harm of a serious nature to a child or custodial parent;

2. Is not in a child's best interest because the child was conceived as a result of rape or incest; or

3. May interfere with adoption considerations or proceedings.

(2) A failure of an individual to cooperate without good cause shall result in ineligibility of the individual.

(3) A pregnant woman eligible under poverty level standards shall not be required to cooperate in establishing paternity or securing support for her unborn child.

Section 10.[12.] Application Process, Initial and Continuing Eligibility Determination. (1) An individual may apply for Medicaid by:

(a) Using the Web site located at www.kynect.ky.gov;

(b) Applying over the telephone by calling:

1. 1-855- 459-6328; or

2. 1-855-326-4654 if deaf or hearing impaired;

(c) Faxing an application to 1-502-573-2007;

(d) Mailing a paper application to Office of Health Benefits Exchange, 12 Mill Creek, Frankfort, Kentucky 40601; or

(e) Going to the applicant's local Department for Community Based Services Office and applying in person.

(2)(a) An application shall be processed (approved, denied, or a request for additional information sent) within forty-five (45) days of application submittal.

(b) Immediately after submittal if there is a variance of ten (10) percent or more regarding income information reported by the applicant versus information available from a trusted source or trusted sources, a request for additional information shall be generated for the applicant requesting documentation to prove the applicant's income.

(c) If a trusted source indicates that an applicant is incarcerated, a request for additional information shall be generated requesting verification of the applicant's incarceration dates.

(d) If an applicant fails to provide information in response to a request for additional information within thirty (30) days of the beginning of the application process, the application shall be denied.

(3)(a) An annual renewal of eligibility shall occur without an individual having to take action to renew eligibility, unless:

1. The individual's eligibility circumstances change resulting in the individual no longer being eligible for Medicaid; or

2. A request for additional information is generated due to a change in income or incarceration status.

(b)1. If an individual receives a request for additional information as part of the renewal process, the individual shall

provide the information requested within forty-five (45) days of receiving the request.

2. If an individual fails to provide the information requested within forty-five (45) days of receiving the request, the individual's eligibility shall be terminated on the forty-fifth day from the request for additional information.

(4) An individual shall be required to report to the department any changes in circumstances or information related to Medicaid eligibility.

Section ~~11.~~~~[13.]~~ Adverse Action, Notice, and Appeals. The adverse action, notice, and appeals provisions established in 907 KAR 20:060 shall apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard.

Section ~~12.~~~~[14.]~~ Miscellaneous Special Circumstances. (1) A woman during pregnancy, and as though pregnant through the end of the month containing the sixtieth day of a period beginning on the last day of pregnancy, or a child under six (6) years of age, as specified in 42 U.S.C. 1396a(l)(1), shall meet the income requirements for this eligibility group in accordance with this administrative regulation.

(2) If an eligible child is receiving covered inpatient services, except for services in a long term care facility or behavioral health services in an inpatient facility on a long-term basis, on a birthday which will make the child ineligible due to age, the child shall remain eligible until the end of the stay for which the covered inpatient services are furnished if the child remains otherwise eligible except for age.

(3) A child born to a woman eligible for and receiving Medicaid shall be eligible for Medicaid as of the date of the child's birth if the child has not reached his or her first birthday.

(4)(a) A parent, including a natural or adoptive parent, may be included for assistance in the case of a family with a child.

(b) If a parent is not included in the case, ~~a~~~~one (1) other~~ caretaker relative or caretaker relatives may be included to the same extent the caretaker relative would have been eligible in the Aid to Families with Dependent Children program using the AFDC methodology in effect on July 16, 1996.

~~(5) [For an individual eligible on the basis of desertion, a period of desertion shall have existed for thirty (30) days, and the effective date of eligibility shall not precede the first day of the month of application.]~~

~~(6)]~~ For an individual eligible on the basis of utilizing his or her excess income for incurred medical expenses, the effective date of eligibility shall be the day the spend-down liability is met.

~~(6)](7) A caretaker relative (not including a child):~~

~~(a) Removed from a family related Medicaid only case due to failure to meet a technical eligibility requirement shall not be eligible for Medicaid as a medically needy individual unless the individual is separately eligible for medical assistance without regard to eligibility as a member of the group from which the individual has been removed; or~~

~~(b) Who is ineligible for K-TAP benefits for failure to comply with K-TAP work requirements shall not be eligible for medical assistance unless the individual is eligible as a pregnant woman.~~

~~(8)(a) Children with a common parent residing in the same household as the common parent shall be included in the same Medicaid case as the common parent unless doing so results in ineligibility of an otherwise eligible household member.~~

~~(b)]~~ If a family member is pregnant, the unborn child shall be considered as a family member for income determination purposes.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 1 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Marchetta Carmicle or Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the provisions and requirements regarding Medicaid eligibility for individuals whose eligibility standard is the modified adjusted gross income (or MAGI.) Such individuals include children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 195 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. Included in the MAGI category are individuals who previously were ineligible for Medicaid benefits due to not meeting certain "technical" criteria (such as having to be aged, blind, or disabled) and whose income exceeded the prior, lower income threshold. This newly eligible group is comprised of adults with no child under the age of nineteen (19), who do not qualify under the category of "caretaker relative", and who are not pregnant. This group is known as the "Medicaid expansion group." Included in the expansion group are incarcerated individuals who are eligible if admitted to an inpatient hospital for at least twenty-four (24) hours and are otherwise eligible for Medicaid. Previously, DMS has covered such care (inpatient hospital care) for incarcerated pregnant women, but now childless adults (such as males) who are incarcerated will be eligible during inpatient hospital admissions lasting at least twenty-four (24) hours. Additionally, under the old Medicaid income eligibility rules, a state examined a person's gross income then subtracted miscellaneous "income disregards" to create a net income used for income eligibility determination purposes. Examples of income disregards (income that could be excluded from the eligibility determination) included some child support payments, certain childcare expenses, and the first ninety (90) dollars of earned income. Furthermore, each state established its own, unique income disregards. The new standard – MAGI – eliminates income disregards and in lieu of disregards establishes the same income standard for all states. Also, the MAGI standard does not count/consider some income (for eligibility determination purposes) that previously was counted as income. One (1) example of such includes Social Security benefits. Previously these benefits were counted as income. The elimination of it will enable the opportunity for individuals under sixty-five (65) who have a disability but previously did not qualify for Medicaid benefits due to having income in excess of the income limit. Additionally, there is no resource test/standard for individuals for whom a modified adjusted gross income is the Medicaid eligibility standard. Lastly, as authorized by the Affordable Care Act, the department shall apply a five (5) percent increase in the income threshold for those whose income threshold is 133 percent of the federal poverty level, but the individual's initial eligibility determination indicates that the individual's income exceeds 133 percent of the federal poverty level.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the provisions and requirements regarding Medicaid eligibility for individuals whose eligibility standard is the modified adjusted gross income. The Affordable Care Act mandates that the modified adjusted gross income be used (effective January 1, 2014) to determine Medicaid eligibility for certain populations rather than the prior Medicaid eligibility rules; thus, the administrative regulation is necessary to comply with the federal mandate.

(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 complying with a federal mandate to establish the modified adjusted gross income as the Medicaid eligibility standard, rather than existing Medicaid eligibility rules, for certain populations of individuals.

(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 complying with a federal mandate to establish the modified adjusted gross income as the Medicaid eligibility standard, rather than existing Medicaid eligibility rules, for certain populations of individuals.

(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 after comments eliminates the "spend-down" eligibility option (an option of subtracting money paid for medical expenses from counting as income for Medicaid eligibility purposes) for the MAGI population; clarifies that the documentation of citizenship requirements do not apply to a lawfully residing non-citizen under nineteen (19); establishes that the eligibility income threshold for pregnant women is 195 percent of the federal poverty level rather than 185 percent of the federal poverty level; and eliminates provisions which do not apply to the MAGI population.

(b) The necessity of the amendment to this administrative regulation: The amendment after comments is necessary to clarify provisions; eliminate provisions which do not apply to the MAGI population; and correct the eligibility income threshold for pregnant women.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment after comments will conform to the content of the authorizing statutes by clarifying provisions; eliminating provisions which do not apply to the MAGI population; and correcting the eligibility income threshold for pregnant women.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying provisions; eliminating provisions which do not apply to the MAGI population; and correcting the eligibility income threshold for pregnant women.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals for whom a modified adjusted gross income will be the Medicaid income eligibility standard are affected by the administrative regulation. The Department for Medicaid Services (DMS) projects that the number of individuals, beginning January 1, 2014, for whom a modified adjusted gross income will be the Medicaid eligibility income standard will be 678,000. Included in this group are over 147,000 individuals who previously did not qualify for Medicaid benefits and are known as the "expansion group." The expansion group consists of adults who are not pregnant, who have no child under nineteen (19), and who are not otherwise eligible for Medicaid. DMS projects the expansion group to grow to almost 188,000 by state fiscal year 2021 which is the year that the federal matching percent drops to its permanent level of ninety (90) percent. DMS anticipates that in state fiscal year (SFY) 2014 over 17,000 individuals who previously or currently qualify for Medicaid coverage under the old rules but did not apply will become eligible as a result of enhanced public awareness of Medicaid and awareness of the Kentucky Health Benefits Exchange or HBE. This is known as the woodwork effect. The Health Benefits Exchange, or HBE, is a program which enables individuals who make too much income to qualify for Medicaid benefits to receive assistance from the federal government in paying health insurance premiums for health insurance purchased through the HBE. The HBE is an open health insurance marketplace administered by the Cabinet for Health and Family Services. Individuals who apply for HBE coverage but are determined to qualify for Medicaid coverage (whether under the old rules or new MAGI rules) will be informed of Medicaid program eligibility. Those that qualify under the MAGI rules will be able to immediately apply for Medicaid through the same mechanism (phone, website, in person) in which they were applying for health insurance via the HBE. DMS projects that the number of people who will gain Medicaid eligibility as a result of the woodwork effect will top out around 21,000 in SFY 2017.

(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. Individuals who wish to receive Medicaid benefits will have to apply for benefits in accordance with the requirements established in this administrative regulation and satisfy the requirements.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals who were eligible under the existing Medicaid eligibility rules (DMS estimates this number to be over 500,000) will benefit by having a simpler eligibility standard - standard which does not consider resources (assets that can be readily converted to cash) for Medicaid eligibility purposes nor certain technical requirements (such as having to be aged, blind, or have a disability.) Under the old Medicaid income eligibility rules, a state examined a person's gross income then subtracted miscellaneous "income disregards" to create a net income used for income eligibility determination purposes. Each state establishes its own, unique income disregards. The new standard - MAGI - eliminates income disregards and in lieu of the disregards establishes the same income standard for all states. Also, the use of MAGI rules will standardize and simplify the income eligibility standard nationwide and help lower administrative costs associated with determining eligibility for individuals. Additionally, DMS estimates that 147,000 individuals who previously were ineligible for Medicaid benefits will qualify in 2014 as a result of Kentucky adopting the federally-authorized eligibility option which increases the income threshold for individuals as well as eliminates certain technical requirements. DMS projects this population to increase to approximately 188,000 in SFY 2021 [the year in which the federal matching rate plateaus at ninety (90) percent.] This group is known as the Medicaid expansion group. Also, incarcerated individuals in the expansion group will benefit by receiving Medicaid coverage during inpatient hospital admissions which lasts longer than twenty-four (24) hours.

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

(a) Initially: DMS's costs associated with covering benefits for the "Medicaid expansion group" will be \$0 for state fiscal year (SFY) 2014 as the cost (projected to be \$563 million) will be entirely federally funded in 2014. However, DMS (and the Department for Community Based Services or DCBS) will experience administrative costs associated with additional staff, system programming, and resources needed to handle the increase in applications. DCBS anticipates a cost of \$2.3 million related to this in SFY 2014. DMS anticipates an administrative cost increase of \$7.6 million in SFY 2014. DMS anticipates an increased cost of \$13 million in SFY 2014 due to the aforementioned woodwork effect expected to generate over 17,000 eligible for Medicaid under the old eligibility rules but who were unaware of the program. Covering inpatient hospital care for qualifying incarcerated individuals will reduce state general fund expenditures as the Department of Corrections currently pays for this care. The projected savings (expenditure reduction) for the Department of Corrections for SFY 2014 is \$1.4 million.

(b) On a continuing basis: DMS's costs associated with covering benefits for the "Medicaid expansion group" in SFY 2015 will be \$0 and DMS projects the federal government's costs (of covering benefits) for the period to be \$1.193 billion. However, DMS and DCBS anticipate an administrative cost due to staffing and resources. DMS projects its administrative costs to elevate to roughly \$18.5 million in SFY 2016 and remain at that level thereafter. DCBS's administrative costs is projected to elevate to, and level off at, \$3.5 million in SFY 2017. Due to the woodwork effect DMS anticipates an increased cost of \$28 million for SFY 2015 with a federal increase of \$66 million. For SFY 2016, DMS's costs for the expansion group will again be \$0 and the federal cost is expected to be \$1.312 billion. DMS projects the woodwork associated costs to be \$31 million state funds and \$72 million in federal funds for SFY 2016. DMS projects the following state and

federal cost amounts for SFY 2017 through SFY 2021 for the expansion group: SFY 2017 (state funds \$33 million/federal funds \$1.26 billion); SFY 2018 (state funds \$74 million/federal funds \$1.271 billion); SFY 2019 (state funds \$91 million/federal funds \$1.307 billion); SFY 2020 (state funds \$124 million/federal funds \$1.330 billion); SFY 2021 (state funds \$151 million/federal funds \$1.361 billion.) DMS projects the following reduction in state fund expenditures as a result of covering incarcerated individuals' inpatient hospital admissions which last at least twenty-four (24) hours [these are reductions in Department of Corrections expenditures]: \$7 million for SFY 2015; \$7.2 million for SFY 2016; \$7.5 million for SFY 2017; \$7.7 million for SFY 2018; \$7.9 million for SFY 2019; \$8.2 million for SFY 2020; and \$8.4 million for SFY 2021. DMS projects the following costs associated with the woodwork effect for SFY 2017 through SFY 2021: SFY 2017 (state funds \$31 million/federal funds \$71 million); SFY 2018 (state funds \$32 million/federal funds \$74 million); SFY 2019 (state funds \$33 million/federal funds \$77 million); SFY 2020 (state funds \$34 million/federal funds \$80 million); SFY 2021 (state funds \$36 million/federal funds \$83 million.)

(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 under the Affordable Care Act and matching funds from 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: Beginning in SFY 2017, DMS will need additional funding to provide the state match for covering the expansion group. The federal match in SFY 2017 will be ninety-five (95) percent; thus, the state matching percent would be five (5) percent in SFY 2017. DMS projects the need to cover the five (5) percent match in SFY 2017 to be \$33 million. DMS projects the following additional state funds needed from SFY 2018 through SFY 2021 as follows: SFY 2018 - \$74 million; SFY 2019 - \$91 million; SFY 2020 - \$124 million; and SFY 2021 - \$151 million. The federal matching rate descends to a plateau of ninety (90) percent from SFY 2021 going forward.

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

(9) Tiering: Is tiering applied? Tiering is not applied as the income standard applies equally to all affected individuals.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14), 42 U.S.C. 1396a(r)(2).

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) authorizes the Cabinet for Health and Family Services 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."

3. Minimum or uniform standards contained in the federal mandate. Effective January 1, 2014, each state's Medicaid program is required – except for certain designated populations - to

determine Medicaid eligibility by using the modified adjusted gross income and is prohibited from using any type of expense, income disregard, or any asset or resource test. The populations governed by the new requirements include children under nineteen (19) [excluding children in foster care]; pregnant women (including the postpartum period up to sixty (60) days; caretaker relatives with income up to 133 percent of the federal poverty level; adults with no child under nineteen (19) with income up to 133 percent of the federal poverty level who are not otherwise eligible for Medicaid benefits; and targeted low-income children with income up to 150 percent of the federal poverty level. Also, states are prohibited from continuing to use income disregards, asset tests, or resource tests for individuals who are eligible via the modified adjusted gross income standard. Additionally, states are prohibited from applying an asset or resource test for eligibility purposes for the aforementioned population. States are also required to create and adopt an income threshold (under the modified adjusted gross income) that ensures that individuals who were eligible for Medicaid benefits prior to January 1, 2014 (the date that the modified adjusted gross income standard is adopted) do not lose Medicaid coverage due to the modified adjusted gross income standard taking effect.

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 (DMS), the Department for Community Based Services (DCBS), and Department of Corrections will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 435.603 and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 is projected to generate \$563 million in federal funds for the Medicaid program in state fiscal year (SFY) 2014 and reduce Department of Corrections' expenditures by \$1.4 million for the same period. Additionally, the University of Louisville's Urban Studies Institute analyzed the projected impact on Kentucky's economy of Kentucky taking advantage of the Medicaid expansion authorized by the Affordable Care Act. USI's assessment projected that the expansion would create 7,600 jobs in SFY 2014 generating an economic impact of over \$905 million including \$293.7 million in wages and salaries with an average annual salary of \$38,000. USI's analysis projects the following tax revenue increases in SFY 2014 as a result of Medicaid expansion: income tax revenues to increase \$12.1 million state, sales tax to increase \$11.9 million, and local occupational and payroll tax revenues to increase \$4.9 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? This administrative regulation is projected to generate \$1.193 billion in federal funds for SFY 2015; \$1.312 billion in federal funds for SFY 2016; \$1.26 billion in federal funds for SFY 2017; \$1.271 billion in federal funds for SFY 2018; \$1.307 billion in

federal funds for SFY 2019; \$1.330 billion in federal funds for SFY 2020; and \$1.361 billion in federal funds for SFY 2021. The aforementioned analysis by the University of Louisville's Urban Studies Institute projected job created by the Medicaid expansion to reach top 16,000 in SFY 2016 and increase to 16,700 in SFY 2021. USI projects the economic impact to top \$2.293 billion in SFY 2021 including \$724.3 million in wages and salaries with an average annual salary of \$43,000. Additionally, USI projects the state income tax increase to reach \$30 million in SFY 2021, the sales tax increase to reach \$29.4 million for the same year, and local occupational and payroll taxes to increase by \$12.0 million for the same year.

(c) How much will it cost to administer this program for the first year? DMS's costs associated with covering benefits for the "Medicaid expansion group" will be \$0 for state fiscal year (SFY) 2014 as the cost (projected to be \$563 million) will be entirely federally funded in 2014. However, DMS (and the Department for Community Based Services or DCBS) will experience administrative costs associated with additional staff, system programming, and resources needed to handle the increase in applications. DCBS anticipates a cost of \$2.3 million related to this in SFY 2014. DMS anticipates an administrative cost increase of \$7.6 million in SFY 2014. DMS anticipates an increased cost of \$13 million in SFY 2014 due to the aforementioned woodwork effect expected to generate over 17,000 eligible for Medicaid under the old eligibility rules but who were unaware of the program. Covering inpatient hospital care for qualifying incarcerated individuals will reduce state general fund expenditures as the Department of Corrections currently pays for this care. The projected savings (expenditure reduction) for the Department of Corrections for SFY 2014 is \$1.4 million.

(d) How much will it cost to administer this program for subsequent years? DMS's costs associated with covering benefits for the "Medicaid expansion group" in SFY 2015 will be \$0 and DMS projects the federal government's costs (of covering benefits) for the period to be \$1.193 billion. However, DMS and DCBS anticipate an administrative cost due to staffing and resources. DMS projects its administrative costs to elevate to roughly \$18.5 million in SFY 2016 and remain at the level thereafter. DCBS's administrative costs is projected to elevate to, and level off at, \$3.5 million in SFY 2017. Due to the woodwork effect DMS anticipates an increased cost of \$28 million for SFY 2015 with a federal increase of \$66 million. For SFY 2016, DMS's costs for the expansion group will again be \$0 and the federal cost is expected to be \$1.312 billion. DMS projects the woodwork associated costs to be \$31 million state funds and \$72 million in federal funds for SFY 2016. DMS projects the following state and federal cost amounts for SFY 2017 through SFY 2021 for the expansion group: SFY 2017 (state funds \$33 million/federal funds \$1.26 billion); SFY 2018 (state funds \$74 million/federal funds \$1.271 billion); SFY 2019 (state funds \$91 million/federal funds \$1.307 billion); SFY 2020 (state funds \$124 million/federal funds \$1.330 billion); SFY 2021 (state funds \$151 million/federal funds \$1.361 billion.) DMS projects the following reduction in state fund expenditures as a result of covering incarcerated individuals' inpatient hospital admissions which last at least twenty-four (24) hours [these are reductions in Department of Corrections expenditures]: \$7 million for SFY 2015; \$7.2 million for SFY 2016; \$7.5 million for SFY 2017; \$7.7 million for SFY 2018; \$7.9 million for SFY 2019; \$8.2 million for SFY 2020; and \$8.4 million for SFY 2021. DMS projects the following costs associated with the woodwork effect for SFY 2017 through SFY 2021: SFY 2017 (state funds \$31 million/federal funds \$71 million); SFY 2018 (state funds \$32 million/federal funds \$74 million); SFY 2019 (state funds \$33 million/federal funds \$77 million); SFY 2020 (state funds \$34 million/federal funds \$80 million); SFY 2021 (state funds \$36 million/federal funds \$83 million.)

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:

PROPOSED AMENDMENTS

KENTUCKY HIGHER EDUCATION ASSISTANCE AUTHORITY
Division of Student and Administrative Services
(Amendment)

11 KAR 4:080. Student aid applications.

RELATES TO: KRS 164.518, 164.744(2), 164.748(4), (7), (8), 164.753(3), (4), (6), 164.7535, 164.769, 164.780, 164.785, 164.7890, 34 C.F.R. 654.1-654.5, 654.30-654.52, 20 U.S.C. 1070d-31 - 1070d-41

STATUTORY AUTHORITY: KRS 164.518(3), 164.746(6), 164.748(4), 164.753(3), (6), 164.7535, 164.769(5), (6)(f), 34 C.F.R. 654.30, 654.41, 20 U.S.C. 1070d-37, 1070d-38

NECESSITY, FUNCTION, AND CONFORMITY: KRS 164.748(4) authorizes the Authority to promulgate administrative regulations pertaining to the awarding of grants, scholarships, and honorary scholarships as provided in KRS 164.740 to 164.7891. This administrative regulation designates and incorporates the applications to be utilized under the grant, scholarship, and work-study programs administered by KHEAA.

Section 1. Applications. In order to participate in a specified grant, scholarship, or work-study program administered by the Kentucky Higher Education Assistance Authority, the following application forms shall be completed in accordance with their instructions:

(1) For the KHEAA Grant Program as set forth in 11 KAR 5:130, the 2014-2015[2013-2014] Free Application for Federal Student Aid (FAFSA);

(2) For the KHEAA Work-Study Program as set forth in 11 KAR 6:010, the KHEAA Work-Study Program Student Application;

(3) For the Teacher Scholarship Program as set forth in 11 KAR 8:030, the Teacher Scholarship Application;

(4) For the Early Childhood Development Scholarship Program as set forth in 11 KAR 16:010:

(a) The 2014-2015[2013-2014] Free Application for Federal Student Aid (FAFSA);

(b) The Early Childhood Development Scholarship Application;

(5) For the Robert C. Byrd Honors Scholarship Program as set forth in 11 KAR 18:010:

(a) For high school and home school students, the Robert C. Byrd Honors Scholarship Program; and

(b) For GED recipients, the Robert C. Byrd Honors Scholarship Program GED Recipients;

(6) For the Go Higher Grant Program as set forth in 11 KAR 5:200;

(a) The 2014-2015[2013-2014] Free Application for Federal Student Aid (FAFSA); and

(b) The Go Higher Grant Program Application; and

(7) For the Coal County Scholarship Program for Pharmacy Students as set forth in 11 KAR 19:010, the Coal County Scholarship Program for Pharmacy Students Application.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) The "Free Application for Federal Student Aid July 1, 2014[2013] – June 30, 2015[2014]" (FAFSA), December 2013[2012];

(b) The "KHEAA Work-Study Program Student Application", July 2001;

(c) The "Teacher Scholarship Application", June 2006;

(d) The "Early Childhood Development Scholarship Application", April 2006;

(e) The "Robert C. Byrd Honors Scholarship Program", June 2009;

(f) The "Robert C. Byrd Honors Scholarship Program-GED Recipients", June 2009;

(g) The "Go Higher Grant Program Application", January 2008; and

(h) The "Coal County Scholarship Program for Pharmacy Students Application", February 2011.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Higher Education Assistance Authority, 100 Airport Road, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. The material may also be obtained at www.kheaa.com.

JOHN CHESHIRE, Chair

APPROVED BY AGENCY: October 9, 2013

FILED WITH LRC: January 10, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014 at 10:00 a.m. Eastern Time at 100 Airport Road, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Ms. Diana L. Barber, General Counsel, Kentucky Higher Education Assistance Authority, P.O. Box 798, Frankfort, Kentucky 40602-0798, phone (502) 696-7298, fax (502) 696-7293.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Diana L. Barber

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation designates and incorporates the applications to be utilized under the grant, scholarship, and work-study program administered by the Authority.

(b) The necessity of this administrative regulation: The Authority is required to promulgate administrative regulations pertaining to the administration of the Early Childhood Development Scholarship Program, KHEAA Work-study Program, Teacher Scholarship Program, College Access Program (CAP), Kentucky Tuition Grant (KTG), and Go Higher Grant Programs as well as the Robert C. Byrd Scholarship Program pursuant to KRS 164.518(3), 164.746(6), 164.748(4), 164.753(3), (6), 164.7535, 164.769(5), (6)(f), 34 C.F.R. 654.30, 654.41, and 20 U.S.C. 1070d-36, 1070d-37, 1070d-38.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by prescribing the applications to be utilized under the grant, scholarship and work-study programs administered by the Authority.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists with the effective administration of the statutes by prescribing and incorporating the various application forms to be used by students to apply for the financial aid programs administered by the authority.

(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 existing regulation by specifying the latest version of the Free Application for Federal Student Aid (FAFSA) for the 2014-2015 academic year that is to be completed by applicants for participation in the student aid programs administered by the Authority.

(b) The necessity of the amendment to this administrative regulation: The amendment to this administrative regulation is necessary in order to require student recipients to complete the

most recent version of the FAFSA.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by updating one of the applications required for participation in the student aid programs administered by the Authority.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the state student aid programs by requiring completion of the most recent version of the FAFSA in order to participate in said programs.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The proposed amendment to this administrative regulation will affect all those individuals who seek to apply for student financial aid through the Authority.

(4) Provide an analysis of how the entities identified in (3) above 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 in order to comply with this administrative regulation or amendment: All potential student aid recipients will be required to complete the 2014-2015 version of the FAFSA in order to apply for financial aid through the Authority.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There will be no cost to the entities noted above in complying with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Those individuals who complete the latest version of the FAFSA specified herein will receive, to the extent otherwise eligible, student financial aid through the Authority.

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

(a) Initially: There is no cost to implement this administrative regulation.

(b) On a continuing basis: See 5(a) above.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: No funding source is required in order to implement this administrative regulation since it merely updates the required version of the FAFSA.

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

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees, nor does it directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering was not applied. It is not applicable to this amendment. This administrative regulation is intended to provide equal opportunity to participate, and consequently does not inherently result in disproportionate impacts on certain classes of regulated entities. The "equal protection" and "due process" clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution. The regulation provides equal treatment and opportunity for all applicants and recipients.

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? Finance and Administration Cabinet, Kentucky Higher Education Assistance Authority.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 164.518(3), 164.746(6), 164.748(4), 164.753(3),

(6), 164.7535, 164.769(5), (6)(f), 34 C.F.R. §654.30, §654.41, 20 U.S.C. §1070d-36, 37, 38.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. The administrative regulation will result in no additional expenditures by or revenues to the Authority during the first full year of its effectiveness.

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

(c) How much will it cost to administer this program for the first year? No costs are associated with this regulation.

(d) How much will it cost to administer this program for subsequent years? No costs are associated with 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 BOARD (Amendment)

101 KAR 1:325. Probationary periods.

RELATES TO: KRS 18A.005, 18A.0751(1)(e), (4)(e), 18A.111

STATUTORY AUTHORITY: KRS 18A.005, 18A.075(1), 18A.0751(1)(e), (4)(e)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 18A.075(1) requires the Personnel Board to promulgate comprehensive administrative regulations consistent with the provisions of KRS 18A.005 to 18A.200. KRS 18A.0751(1)(e) requires the Personnel Board to promulgate comprehensive administrative regulations for the classified service governing probation. KRS 18A.0751(4)(e) authorizes the Personnel Board to promulgate administrative regulations to establish an initial probationary period in excess of six (6) months for specific job classifications. KRS 18A.111 establishes requirements governing initial and promotional probationary periods for classified service. This administrative regulation establishes the requirements relating to probationary periods.

Section 1. Initial Probationary Period. (1) The initial probationary period shall be computed from the effective date of appointment to the corresponding date in the sixth or final month, depending upon the length of initial probationary period, except as provided in KRS 18A.111.

(2) The following job classifications shall require an initial probationary period in excess of six (6) months:

Title Code	Job Classification	Length of Initial Probationary Period
1555	Resort Park Manager I	12 months
1556	Resort Park Manager II	12 months
1557	Resort Park Manager III	12 months
1580	Park Business Manager I	12 months
1581	Park Business Manager II	12 months
1585	Park Manager I/Historic Site Manager	12 months
1586	Park Manager II	12 months
1588	Park Manager III	12 months
2001	Conservation Officer Recruit	12 months
2201	Correctional Officer	8 months
2308	Facilities Security Sergeant	12 months

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2309	Facilities Security Lieutenant	12 months
2313	State Park Ranger Recruit	12 months
2322	Facilities Security Officer II	12 months
2350	Mounted Patrol Officer Recruit	12 months
2401	Police Telecommunicator I	12 months
2403	Police Telecommunicator II	12 months
2404	Police Telecommunications Shift Supervisor	12 months
2405	Police Telecommunications Supervisor	12 months
2408	CVE Inspector I	12 months
2410	CJIS (Criminal Justice Information System) Compliance Specialist I	12 months
2411	CJIS Compliance Specialist II	12 months
2412	CJIS Compliance Specialist III	12 months
2413	CJIS Compliance Supervisor	12 months
2415	Transportation Operations Center Specialist I	12 months
2433	Polygraph Examiner II	12 months
2434	Polygraph Examiner I	12 months
2460	Driver's Test Administrator	12 months
2468	Fish and Wildlife Telecommunicator I	12 months
3254	Boiler Inspector I	12 months
3268	Fire Protection Systems Inspector	12 months
3416	Financial Institutions Examiner I	12 months
3417	Financial Institutions Examiner II	12 months
3432	Financial Institutions Examiner III	12 months
3433	Financial Institutions Examiner IV	12 months
3434	Financial Institutions Examiner Specialist	12 months
3551	Insurance Fraud Investigator II	12 months
3552	Insurance Fraud Investigator III	12 months
3553	Insurance Fraud Investigator Supervisor	12 months
4056	Forensic Firearms and Toolmark Examiner I	12 months
4058	Forensic Chemist I	12 months
4059	Forensic Chemist II	12 months
4061	Forensic Biologist I	12 months
4062	Forensic Biologist II	12 months
4125	Therapy Program Assistant	9 months
4140	Houseparent I	12 months
4141	Houseparent II	12 months
4143	Audiologist I	12 months
4301	Patient Aide I	9 months
4550	Medical Investigator I	12 months
4551	Medical Investigator II	12 months
5120	Student Development Associate	12 months
5121	Student Development Assistant	12 months
5362	KSB/KSD (Kentucky School for the Blind/Kentucky School for the Deaf) Administrator I	12 months
5364	KSB/KSD Administrator III	12 months
5365	KSB/KSD Administrator IV	12 months
5366	KSB/KSD Administrator V	12 months
5367	KSB/KSD Administrator VI	12 months
6215	Disability Adjudicator I	12 months
6248	Juvenile Facility Superintendent I	12 months
6249	Juvenile Facility Superintendent III	12 months
6250	Facilities Regional Administrator	12 months
6251	Youth Services Program Supervisor	12 months
6252	Juvenile Facility Superintendent II	12 months
6267	Human Rights Specialist	12 months
6290	Administrative Hearing Officer I	12 months
6292	Human Rights Enforcement Branch Manager	12 months
6296	Human Rights Research/Information Compliance Supervisor	12 months
6297	Human Rights Housing Compliance	12 months

	Supervisor	
6298	Human Rights Employment/Public Accommodations Compliance Supervisor	12 months
6299	Human Rights Compliance Enforcement Officer II	12 months
6301	Probation and Parole Officer I	12 months
6401	Youth Worker I	12 months
6404	Youth Worker Supervisor	12 months
6410	Juvenile Services District Supervisor	12 months
7213	Forestry District Equipment Supervisor	12 months
7215	Nursery Foreman	12 months
7217	Nursery Superintendent	12 months
7222	Forester	12 months
7224	Forester Chief	12 months
7226	Forester District	12 months
7231	Rural Fire Suppression Technical Advisor	12 months
7232	Forestry Program Specialist	12 months
7235	Forestry Program Manager	12 months
7236	Forestry Program Supervisor	12 months
7250	Forest Ranger Technician I	12 months
7251	Forest Ranger Technician II	12 months
7252	Forest Ranger Technician III	12 months
7253	Forest Ranger Technician District	12 months
8326	Right-of-way Agent I	12 months
9635	Criminal Intelligence Analyst I	12 months
9636	Criminal Intelligence Analyst II	12 months
9816	Public Advocate Investigator I	12 months
9859	Environmental Administrative Hearing Officer	12 months
9866	Mitigation Specialist I	12 months
9885	Investigator I	12 months

(3) If the length of the initial probationary period for a job classification is changed, an employee serving an initial probationary period on the effective date of the change shall serve the shorter of the initial probationary periods. When the employee is appointed, the employee's appointing authority shall advise the employee of the period of his initial probation.

Section 2. Promotional Probationary Period. (1) An employee who satisfactorily completes the promotional probationary period shall be granted status in the position to which he has been promoted. Unless an employee receives notice prior to the end of his promotional probationary period that he has failed to satisfactorily complete the promotional probationary period and that he is being reverted, the employee shall be deemed to have served satisfactorily and shall acquire status in the position to which he has been promoted.

(2) An employee who fails to satisfactorily complete a promotional probationary period shall be reverted to his former position or to a position in the same job classification as his former position. A written notification shall be sent to the employee to advise the employee of the effective date of reversion. A copy of the notice of reversion shall be forwarded to the Secretary of Personnel on the same date notice is delivered to the employee.

(3) The promotional probationary period shall be computed from the effective date of promotion to the corresponding date in the appropriate month following promotion, as required by KRS 18A.005(27), except as provided in KRS 18A.111.

(4) The promotional probationary period shall be the same length as the initial probationary period for each job classification.

Section 3. Probationary Period Upon Reinstatement. (1) An employee who is reinstated, except an employee ordered reinstated pursuant to KRS 18A.111(3), to a position in the classified service no later than twelve (12) months after the beginning of a break in the classified service shall be reinstated with status.

(2) An employee who is reinstated to the classified service

more than twelve (12) months after a break in service, except an employee ordered reinstated pursuant to KRS 18A.111(3), shall serve an initial probationary period.

MARK A. SIPEK, Executive Director

APPROVED BY AGENCY: January 15, 2014

FILED WITH LRC: January 15, 2014 at 9 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014, at 9:00 a.m. Eastern Time at the Kentucky Personnel Board, 28 Fountain Place, Frankfort, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by February 14, 2014, 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 wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments to:

CONTACT PERSON: Boyce A. Crocker, General Counsel, Personnel Board, 28 Fountain Place, Frankfort, Kentucky 40601, phone (502) 564-7830, fax (502) 564-1693.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Boyce A. Crocker

(1) Provide a brief summary of:

(a) What this administrative regulation does: The regulation sets forth the classifications for which an initial probationary period in excess of six (6) months is required.

(b) The necessity of this administrative regulation: To establish the appropriate probationary periods for classifications throughout state government.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 18A.0751(4)(e) requires the Personnel Board to promulgate an administrative regulation listing the job classifications for which an initial probationary period in excess of six (6) months is required. It also makes clear that a promotional probationary period shall mirror the initial promotional period for a particular job classification.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation sets forth the classifications for which an initial probationary period in excess of six (6) months is required.

(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 provides an initial probationary period of twelve months for Park Business Manager I, Park Business Manager II, Insurance Fraud Investigator III, and Insurance Fraud Investigator Supervisor.

(b) The necessity of the amendment to this administrative regulation: Secretary of the Personnel Cabinet has recommended changes to the classifications for which an initial probationary period in excess of six (6) months is required.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment consists of changes to the list of classifications for which an initial probationary period in excess of six (6) months is required. It also makes clear that a promotional probationary period shall mirror the initial promotional period for a particular job classification.

(d) How the amendment will assist in the effective administration of the statutes: This amendment is necessary to meet state agency needs and allow for longer probationary periods for Park Business Manager I, Park Business Manager II, Insurance Fraud Investigator III, and Insurance Fraud Investigator Supervisor.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this

administrative regulation: All state employees appointed to the listed classifications, and the state government agencies that employ them.

(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: None

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): None

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The Tourism, Arts and Heritage Cabinet, Department of Parks and the Public Protection Cabinet, Department of Insurance will be able to more fully observe the job performance of initial probationary employees in the affected classifications to determine if those employees should gain status in the classified service.

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

(a) Initially: None

(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: Not applicable.

(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: Not applicable.

(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? This regulation must apply equally to all classified employees in all state agencies with classified employees.

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? Department of Parks and Department of Insurance

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 18A.0751 and KRS 18A.111

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(a) 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? Not applicable

(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? Not applicable

(c) How much will it cost to administer this program for the first year? Not applicable

(d) How much will it cost to administer this program for subsequent years? Not applicable

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

**FINANCE AND ADMINISTRATION CABINET
Department of Revenue
(Amendment)**

103 KAR 3:010. General Administrative Forms Manual.

RELATES TO: KRS 42.470, 61.870-61.884, 64.012, 131.010(9), 131.020, 131.030, 131.041, 131.051, 131.061, 131.081, 131.081(2), (9), (15), 131.110, 131.130, 131.130(3), (10), (11), 131.150, 131.155, 131.170, 131.181, 131.183, 131.190, 131.190(1), 131.240, 131.340, 131.500, 131.500(1), (2), (3), (9), (10), 131.510(1), (2)(a), (2)(b), 131.530, 131.540, 132.020, 132.130-132.160, 132.180, 132.190, 132.200, 132.220, 132.227, 132.230, 132.260, 132.270, 132.290, 132.310, 132.320, 132.450, 132.487, 132.510, 132.820, 132.990, 133.045, 133.110, 133.120, 133.130, 133.240, 134.020, 134.390, 134.420, 134.430, 134.440, 134.500, 134.580(4), 134.590, 134.800, 134.805, 134.810, 134.815, 134.820, 134.825, 134.830, 135.010, 135.020, 135.050, 136.020, 136.050, 136.070, 136.071, 136.0704, 136.090, 136.100, 136.115-136.180, 136.1873, 136.310, 136.320, 136.330, 136.335, 136.377, 136.392, 136.545, 136.575, 136.600-136.660, 137.130, 137.160, 138.448, 138.885, 139.185, 139.200, 139.240, 139.330, 139.390, 139.550, 141.0401(5), 141.0401(6), 141.050(4), 141.210, 141.235, 141.340(2), 142.010, 142.050, 142.321, 142.327, 142.357, 143.030(1), 143.037, 143.040, 143.050, 143.060(1), 143.085, 143.990, 143A.010, 143A.030, 143A.035, 143A.037, 143A.080, 143A.090, 143A.100(1), 143A.991, 154.22-050, 154.22-060, 154.22-070, 154.23-010, 154.24-110, 154.24-130, 154.26-090, 154.28-090, 154.34-010, 155.170, 160.613-160.617, 160.6154(3), 205.745, 209.160, 224.01-310(1), 234.321, 234.370, 243.710, 243.720, 243.730, 243.850, 243.884, 248.756(2), 299.530, 304.4-030, 304.11-050, 304.49-220, 351.175, 395.470(3), 413.120.

STATUTORY AUTHORITY: KRS 131.130(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue Forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

Section 1. Administrative - Required Forms. (1) Revenue Form 10A001, "Request to Inspect Public Records", shall be completed by the public to request access to public records specified on the form.

(2) Revenue Form 10A020, "Waiver of Appeal Rights", shall be completed by a taxpayer to reopen an audit that has become final if the taxpayer has failed to timely file a protest with the Department of Revenue.

(3) Revenue Form 10A070, "Authorization Agreement for Electronic Funds Transfer", shall be completed by taxpayers to authorize the Department of Revenue to move funds by electronic means from taxpayer accounts to the Department of Revenue as payment for taxes.

(4) Revenue Form 10A071, "EFT Bank Change", shall be completed by taxpayers who are registered as EFT ACH Debit filers to notify the department of a bank account change.

(5) Revenue Form 10A100(P), "Kentucky Tax Registration Application and Instructions", shall:

(a) Be used by taxpayers to voluntarily apply for tax registration of the following accounts:

1. Employer's Kentucky withholding tax;
2. Corporation income tax;
3. Sales and use tax;
4. Consumer's use tax;
5. Motor vehicle tire fee;
6. Transient room tax;
7. Limited liability entity tax;
8. Utility Gross Receipts License tax;
9. Telecommunications tax;
10. Coal severance and processing tax; or

11. Coal Seller/Purchaser Certificate ID Number; and
(b) Provide the department the necessary information to properly register the taxpayer for all applicable tax accounts, including the legal business name, federal employer identification number (FEIN), address and other demographic information for the business, and each responsible party's information including full name, social security number, and residential address.

(6) Revenue Form 10A100-CS(P), "Kentucky Tax Registration Application and Instructions", shall:

(a) Be sent by the department's Division of Registration and Data Integrity to non-compliant taxpayers for the taxpayers to apply for tax registration of the following accounts:

1. Employer's Kentucky withholding tax;
2. Corporation income tax;
3. Sales and use tax;
4. Consumer's use tax;
5. Motor vehicle tire fee;
6. Transient room tax;
7. Limited liability entity tax;
8. Utility Gross Receipts License tax;
9. Telecommunications tax;
10. Coal severance and processing tax; or
11. Coal Seller/Purchaser Certificate ID Number; and

(b) Provide the department the necessary information to properly register the taxpayer for all applicable tax accounts, including the legal business name, federal employer identification number (FEIN), address and other demographic information for the business, and each responsible party's information including full name, social security number, and residential address.

(7) Revenue Form 10A104, "Update or Cancellation of Kentucky Tax Account(s)", shall:

(a) Be used by the taxpayer to update business information or to cancel accounts for the following taxes:

1. Employer's Kentucky withholding tax;
2. Corporation income tax;
3. Sales and use tax;
4. Consumer's use tax;
5. Motor vehicle tire fee;
6. Transient room tax;
7. Limited liability entity tax;
8. Utility Gross Receipts License tax;
9. Telecommunications tax; or
10. Coal severance and processing tax; and

(b) Provide the department the necessary information to properly update and maintain demographic information of the business for all applicable tax accounts, including the legal business name, federal employer identification number (FEIN), address and other demographic information for the business, and each responsible party's information including full name, social security number, and residential address.

(8) Revenue Form 10A104-I, "Instructions Update or Cancellation of Kentucky Tax Account(s)", shall provide instructions for the proper completion of Revenue Form 10A104.

(9) Revenue Form 10A106, "Appointment of Taxpayer Administrator and Authorized Users for Kentucky Online Tax", shall be used to establish a taxpayer administrator and authorized users for use of the Kentucky Online Tax System.

(10) Revenue Form 10A2000, "Request for Return/Information", shall be used to request information from the disclosure office as an inter-agency request or as a request from an outside agency.

(11) Revenue Form 10F060, "Electronic Funds Transfer Program: ACH Credit Guide", shall provide information on the specific requirements of the Department of Revenue's Credit Method of tax remittance for the Electronic Funds Transfer Program.

(12) Revenue Form 10F061, "Electronic Funds Transfer Program: Debit Guide", shall provide instructions to the taxpayer on how to authorize the Department of Revenue to electronically debit a taxpayer controlled account in an Automated Clearing House participating financial institution for the amount which the taxpayer reports to the state's data collection service.

(13) Revenue Form 10F100, "Your Rights As a Kentucky

Taxpayer", shall provide the public with information describing taxpayer rights provided by KRS Chapters 131, 133, and 134.

(14) Revenue Form 12A012, "Receipt of Seized Property", shall be presented for execution to the taxpayer receiving returned property from the Kentucky Department of Revenue that was previously seized for failure to pay taxes in order to establish documentation that the property was returned to the taxpayer.

(15) Revenue Form 12A018, "Kentucky Department of Revenue Offer in Settlement Application", shall be presented for execution to persons requesting to settle their tax liabilities for less than the delinquent tax liability based upon doubt as to collectability or doubt as to liability.

(16) Revenue Form 12A104, "Notice of Seizure", shall be presented to the owner or officer of the entity from which the Kentucky Department of Revenue is seizing property for failure to pay taxes owed to the Commonwealth.

(17) Revenue Form 12A107, "Notice of Sale", shall be presented to the owner of seized property, published in the newspaper with the highest circulation for that area, and posted at the courthouse, at three (3) other public places within the county, and where the seizure was made, for the purpose of notifying the property owner, and advertising to the public the sale of the seized property.

(18) Revenue Form 12A109-1, "Release of Bank Levy", shall be presented to the bank on which the levy was served for the purpose of releasing the seized property.

(19) Revenue Form 12A109-2, "Release of Levy", shall be presented to the party on which the levy was served for the purpose of releasing the seized property.

(20) Revenue Form 12A109-3, "Release of Levy", shall be presented to the party on which the levy was served for the purpose of releasing the seized property related to child support.

(21) Revenue Form 12A110, "Release of Levy on Wages, Salary, and Other Income", shall be presented to an employer for the purpose of releasing a wage levy.

(22) Revenue Form 12A110-1, "Release of Levy on Wages, Salary, and Other Income", shall be presented to an employer for the purpose of releasing a wage levy related to child support.

(23) Revenue Form 12A500, "Certificate of Partial Discharge of Tax Lien", shall be presented to anyone who makes a proper application for a lien release on a specific piece of property if the Department of Revenue's lien attaches no equity or if the equity that the lien encumbers is paid to the Department of Revenue.

(24) Revenue Form 12A501, "Certificate of Subordination of Kentucky Finance and Administration Tax Lien", shall be presented to anyone who makes proper application requesting that the Department of Revenue subordinate its lien position to a new mortgage and demonstrates that the subordination is in the Commonwealth's best interest.

(25) Revenue Form 12A502, "Application for Certificate of Subordination of Kentucky Tax Lien", shall be presented to anyone who requests to have the Department of Revenue subordinate its lien position to a new mortgage.

(26) Revenue Form 12A503, "Application for Specific Lien Release", shall be presented to anyone who requests that the Department of Revenue release its tax lien so that a specific piece of property can be sold.

(27) Revenue Form 12A504, "Personal Assessment of Corporate Officer or LLC Manager", shall be presented to a corporate officer for the purpose of establishing responsibility of payment of trust taxes owed to the Commonwealth.

(28) Revenue Form 12A505, "Waiver Extending Statutory Period of Assessment of Corporate Officer or LLC Manager", shall be presented to the corporate officers or LLC managers for the purpose of entering into a payment agreement to pay the trust taxes owed to the Commonwealth, and the terms of the payment agreement shall extend past the statutory period for assessing responsible corporate officers or LLC managers.

(29) Revenue Form 12A506, "Waiver Extending Statutory Period for Collection", shall be presented to the taxpayer for the purpose of extending the period in which the liability can be collected.

(30) Revenue Form 12A507, "Table for Figuring the Amount

Exempt From Levy on Wages, Salary, and Other Income", shall be presented to employers with a wage levy on an employee for the purpose of calculating the dollar amount of wages due to the employee.

(31) Revenue Form 12A508-1, "Notice of Tax Due", shall be presented for the purpose of assessing an officer of a corporation who is personally liable for trust taxes owed to the Commonwealth.

(32) Revenue Form 12A508-2, "Notice of Tax Due", shall be presented for the purpose of assessing an officer of a corporation who is personally liable for Gasoline and Special Fuels taxes owed to the Commonwealth.

(33) Revenue Form 12A508-3, "Notice of Tax Due", shall be presented for the purpose of assessing a manager or partner of a limited liability company who is personally liable for trust taxes owed to the Commonwealth.

(34) Revenue Form 12A508-4, "Notice of Tax Due", shall be presented for the purpose of assessing a manager or partner of a limited liability company who is personally liable for Gasoline and Special Fuels taxes owed to the Commonwealth.

(35) Revenue Form 12A514, "Questionnaire for Persons Relative to a Notice of Assessment", shall be presented to an officer of a corporation for the purpose of resolving responsibility of the trust taxes owed to the Commonwealth.

(36) Revenue Form 12A517, "Notice of Lien", shall be presented to the county clerk for appropriate recording and to the taxpayer against whom the lien is filed for the purpose of filing and recording the tax lien in the county clerk's office and giving notification to the taxpayer.

(37) Revenue Form 12A517-1, "Notice of Child Support Lien", shall be presented to the county clerk for appropriate recording and to the taxpayer against whom the lien is filed for the purpose of filing and recording the tax lien in the county clerk's office and giving notification to the taxpayer.

(38) Revenue Form 12A518, "Certificate of Release of Lien", shall be presented to the county clerk and to the taxpayer against whom the tax lien is filed for the purpose of releasing the lien and notifying the taxpayer of the release.

(39) Revenue Form 12A518-1, "Certificate of Release of Child Support Lien", shall be presented to the county clerk and to the taxpayer against whom the child support lien is filed for the purpose of releasing the lien and notifying the obligor of the release.

(40) Revenue Form 12A638, "Statement of Financial Condition for Individuals", shall be presented to individuals requesting to make payments or settle their tax liability to the Commonwealth for the purpose of establishing the financial ability to make payments or settle.

(41) Revenue Form 12A638(I), "Instructions for Completing Statement of Financial Condition for Individuals", shall provide instructions for completing Revenue Form 12A638.

(42) Revenue Form 12A639, "Statement of Financial Condition for Businesses", shall be presented to business owners requesting to make payments or settle a tax liability to the Commonwealth for the purpose of establishing the financial ability to make payments or settle.

(43) Revenue Form 12A639(I), "Instructions for Completing Statement of Financial Condition for Businesses", shall provide instructions for completing Revenue Form 12A639.

(44) Revenue Form 12B019, "Notice of Levy on Wages, Salary, and Other Income", shall be presented to employers for the purpose of levying wages from an employee who owes taxes to the Kentucky Department of Revenue.

(45) Revenue Form 12B019-1, "Notice of Levy on Wages, Salary, and Other Income", shall be presented to employers for the purpose of levying wages from an employee who owes child support.

(46) Revenue Form 12B020, "Notice of Levy", shall be presented to banks for the purpose of levying bank accounts of taxpayers who owe taxes to the Kentucky Department of Revenue.

(47) Revenue Form 12B020-2, "Notice of Levy", shall be presented to banks for the purpose of levying bank accounts of obligors who owe child support.

(48) Revenue Form 21A020, "Request for Copy of Tax Refund

Check", shall be completed and submitted to the Department of Revenue in order to obtain a copy of a cashed refund check.

(49) Revenue Form 30A005, "Temporary Vendor's Sales Tax Permit", shall be presented to temporary and transient vendors who do not have a permanent place of business for the purpose of remitting tax on a non-permit basis, as required by 103 KAR 25:060.

(50) Revenue Form 30A006, "Temporary Vendor Sales and Use Tax Return/Processing Document", shall be used to register temporary vendors who do business in the Commonwealth of Kentucky.

(51) Revenue Form 30A872, "Record of Money Receipt Issued", shall be used by Department of Revenue Field personnel to provide written documentation of acceptance of cash payments.

(52) Revenue Form 31A001, "Vendor Contact Authorization", shall be used by a Department of Revenue representative to obtain permission from a taxpayer to contact his or her vendors concerning the issuance of exemption certificates.

(53) Revenue Form 31A004, "Auditor Record of Money Receipt Issued", shall be used by the auditor to acknowledge payment from taxpayers of taxes determined to be tentatively due at the time of an audit.

(54) Revenue Form 31A011-ASH, "Taxpayer Data Questionnaire", shall be used by auditors at the Ashland Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(55) Revenue Form 31A011-BG, "Taxpayer Data Questionnaire", shall be used by auditors at the Bowling Green Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(56) Revenue Form 31A011-CKY, "Taxpayer Data Questionnaire", shall be used by auditors at the Central Kentucky Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(57) Revenue Form 31A011-COR, "Taxpayer Data Questionnaire", shall be used by auditors at the Corbin Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(58) Revenue Form 31A011-HOP, "Taxpayer Data Questionnaire", shall be used by auditors at the Hopkinsville Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(59) Revenue Form 31A011-LOU, "Taxpayer Data Questionnaire", shall be used by auditors at the Louisville Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(60) Revenue Form 31A011-NKY, "Taxpayer Data Questionnaire", shall be used by auditors at the Northern Kentucky Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(61) Revenue Form 31A011-OWEN, "Taxpayer Data Questionnaire", shall be used by auditors at the Owensboro Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(62) Revenue Form 31A011-PAD, "Taxpayer Data Questionnaire", shall be used by auditors at the Paducah Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(63) Revenue Form 31A011-PIKE, "Taxpayer Data Questionnaire", shall be used by auditors at the Pikeville Taxpayer Service Center to gather information regarding a taxpayer's capability to provide electronic data as requested under KRS 131.240.

(64) Revenue Form 31A012, "Interstate Sales/Income Tax

Questionnaire", shall be used to establish possible taxing jurisdiction for sales and use tax and income tax for the states of Ohio and Indiana.

(65) Revenue Form 31A014, "SEATA - Southeastern Association of Tax Administrators Nexus Questionnaire", shall be used to establish possible taxing jurisdiction for sales and use tax and income tax for the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Tennessee, Virginia and West Virginia.

(66) Revenue Form 31A020, "Office of Field Operations Request for Copy of Tax Return(s)", shall be used by Department of Revenue representatives to obtain permission from a taxpayer to release tax returns.

(67) Revenue Form 31A050, "Electronic Transmittal Authorization", shall be used by auditors to seek permission from a taxpayer to transmit audit results electronically.

(68) Revenue Form 31A110, "Office of Field Operations Estimated/Jeopardy Assessment", shall be used for Taxpayer Service Centers to request approval to submit estimated/jeopardy assessments.

(69) Revenue Form 31A114, "Property Audit Request", shall be used by PVAs to submit audit requests for property tax.

(70) Revenue Form 31A115, "Agreement Fixing Test Periods", shall be used by auditors to establish certain test periods when conducting an audit.

(71) Revenue Form 31A149, "Agreement Fixing Period of Limitation Upon Assessment of Sales, Use or Severance Tax", shall be completed by a taxpayer and a representative of the Kentucky Department of Revenue whereby both parties consent and agree that certain sales, use or severance tax deficiencies or overpayments for specific periods may be assessed or refunded beyond the normal four (4) year statute of limitations.

(72) Revenue Form 31A150, "Agreement Fixing Period of Limitation Upon Assessment of Utility Gross Receipts License Tax", shall be used by auditors to establish taxable periods to be held open for audit and date of assessment.

(73) Revenue Form 31A151, "Agreement Fixing Period of Limitation Upon Assessment of Sales or Use for Authorized EDP Holders", shall be used to document an agreement fixing period of audit for sales or use tax field audits for EDP holders.

(74) Revenue Form 31A200, "Reporting Agreement", shall be used to document an agreement between the Department of Revenue and taxpayer regarding sales tax.

(75) [(74)] Revenue Form 31A685, "Authorization to Examine Bank Records", shall be used by the Department of Revenue to obtain permission from a taxpayer to examine records in connection with transactions at the taxpayer's bank.

(76) [(75)] Revenue Form 31A800, "IIT Review History Document", shall be used to record interaction with the taxpayer during an individual income tax review conducted by compliance officers.

(77) [(76)] Revenue Form 31A725, "Statute of Limitations Agreement", shall be completed by a taxpayer and a representative of the Kentucky Department of Revenue whereby both parties consent and agree that certain income tax deficiencies or overpayments for specific periods may be assessed or refunded beyond the normal four (4) year statute of limitations.

(78) [(77)] Revenue Form 31F006, "Southeastern States Information Exchange Program", shall be used to provide information to taxpayers concerning the information exchange program between the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Tennessee, Virginia, and West Virginia.

(79) [(78)] Revenue Form 31F010, "Kentucky's Computer Assisted Audit Program", shall be the brochure used as instructions for taxpayers who submit tax records in an electronic format.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Revenue Form 10A001, "Request to Inspect Public Records", February 1997;

(b) Revenue Form 10A020, "Waiver of Appeal Rights", January

2001;

(c) Revenue Form 10A070, "Authorization Agreement for Electronic Funds Transfer", January 2008;

(d) Revenue Form 10A071, "EFT Bank Change", June 2009;

(e) Revenue Form 10A100(P), "Kentucky Tax Registration Application and Instructions", July 2013~~[August 2012]~~;

(f) Revenue Form 10A100-CS(P), "Kentucky Tax Registration Application and Instructions", July 2013~~[August 2012]~~;

(g) Revenue Form 10A104, "Update or Cancellation of Kentucky Tax Account(s)", June 2011;

(h) Revenue Form 10A104-I, "Instructions Update or Cancellation of Kentucky Tax Account(s)", June 2011;

(i) Revenue Form 10A106, "Appointment of Taxpayer Administrator and Authorized Users for Kentucky Online Tax", May 2010;

(j) Revenue Form 10A2000, "Request for Return/Information", October 2011;

(k) Revenue Form 10F060, "Electronic Funds Transfer Program: ACH Credit Guide", April 2006;

(l) Revenue Form 10F061, "Electronic Funds Transfer Program: Debit Guide", December 2008;

(m) Revenue Form 10F100, "Your Rights as a Kentucky Taxpayer", July 2013~~[October 2010]~~;

(n) Revenue Form 12A012, "Receipt of Seized Property", November 2006;

(o) Revenue Form 12A018, "Kentucky Department of Revenue Offer in Settlement Application", August 2012~~[June 2011]~~;

(p) Revenue Form 12A104, "Notice of Seizure", October 1982;

(q) Revenue Form 12A107, "Notice of Sale", January 2000;

(r) Revenue Form 12A109-1, "Release of Bank Levy", September 2004;

(s) Revenue Form 12A109-2, "Release of Levy", January 2000;

(t) Revenue Form 12A109-3, "Release of Levy", January 2008;

(u) Revenue Form 12A110, "Release of Levy on Wages, Salary, and Other Income", September 2004;

(v) Revenue Form 12A110-1, "Release of Levy on Wages, Salary, and Other Income", January 2008;

(w) Revenue Form 12A500, "Certificate of Partial Discharge of Tax Lien", June 2006;

(x) Revenue Form 12A501, "Certificate of Subordination of Kentucky Finance and Administration Tax Lien", June 2006;

(y) Revenue Form 12A502, "Application for Certificate of Subordination of Kentucky Tax Lien", October 2006;

(z) Revenue Form 12A503, "Application for Specific Lien Release", October 2006;

(aa) Revenue Form 12A504, "Personal Assessment of Corporate Officer or LLC Manager", June 2003;

(bb) Revenue Form 12A505, "Waiver Extending Statutory Period of Assessment of Corporate Officer or LLC Manager", June 2003;

(cc) Revenue Form 12A506, "Waiver Extending Statutory Period for Collection", June 2003;

(dd) Revenue Form 12A507, "Table for Figuring the Amount Exempt from Levy on Wages, Salary, and Other Income", November 2006;

(ee) Revenue Form 12A508-1, "Notice of Tax Due", January 2008;

(ff) Revenue Form 12A508-2, "Notice of Tax Due", January 2008;

(gg) Revenue Form 12A508-3, "Notice of Tax Due", November 2008;

(hh) Revenue Form 12A508-4, "Notice of Tax Due", November 2008;

(ii) Revenue Form 12A514, "Questionnaire for Persons Relative to a Notice of Assessment", August, 1996;

(jj) Revenue Form 12A517, "Notice of Lien", November 2011;

(kk) Revenue Form 12A517-1, "Notice of Child Support Lien", November 2008;

(ll) Revenue Form 12A518, "Certificate of Release of Lien", November 2008;

(mm) Revenue Form 12A518-1, "Certificate of Release of Child Support Lien", January 2008;

(nn) Revenue Form 12A638, "Statement of Financial Condition for Individuals", July 2004;

(oo) Revenue Form 12A638(I), Instructions for Completing Statement of Financial Condition for Individuals", August 2004;

(pp) Revenue Form 12A639, "Statement of Financial Condition for Businesses", August 2004;

(qq) Revenue Form 12A639(I), "Instructions for Completing Statement of Financial Condition for Businesses", August 2004;

(rr) Revenue Form 12B019, "Notice of Levy on Wages, Salary, and Other Income", September 2004;

(ss) Revenue Form 12B019-1, "Notice of Levy on Wages, Salary, and Other Income", September 2011;

(tt) Revenue Form 12B020, "Notice of Levy", September 2004;

(uu) Revenue Form 12B020-2, "Notice of Levy", January 2008;

(vv) Revenue Form 21A020, "Request for Copy of Tax Refund Check", November 2011~~[October 2006]~~;

(ww) Revenue Form 30A005, "Temporary Vendor's Sales Tax Permit", September 1998;

(xx) Revenue Form 30A006, "Temporary Vendor Sales and Use Tax Return/Processing Document", December 2006;

(yy) Revenue Form 30A872, "Record of Money Receipt Issued", October 2000;

(zz) Revenue Form 31A001, "Vendor Contact Authorization", July 2006;

(aaa) Revenue Form 31A004, "Auditor Record of Money Receipt Issued", July 2006;

(bbb) Revenue Form 31A011-ASH, "Taxpayer Data Questionnaire", December 2011;

(ccc) Revenue Form 31A011-BG, "Taxpayer Data Questionnaire", December 2011;

(ddd) Revenue Form 31A011-CKY, "Taxpayer Data Questionnaire", December 2011;

(eee) Revenue Form 31A011-COR, "Taxpayer Data Questionnaire", December 2011;

(fff) Revenue Form 31A011-HOP, "Taxpayer Data Questionnaire", December 2011;

(ggg) Revenue Form 31A011-LOU, "Taxpayer Data Questionnaire", December 2011;

(hhh) Revenue Form 31A011-NKY, "Taxpayer Data Questionnaire", December 2011;

(iii) Revenue Form 31A011-OWEN, "Taxpayer Data Questionnaire", December 2011;

(jjj) Revenue Form 31A011-PAD, "Taxpayer Data Questionnaire", December 2011;

(kkk) Revenue Form 31A011-PIKE, "Taxpayer Data Questionnaire", December 2011;

(lll) Revenue Form 31A012, "Interstate Sales/Income Tax Questionnaire", July 2006;

(mmm) Revenue Form 31A014, "SEATA - Southeastern Association of Tax Administrators Nexus Questionnaire", July 2006;

(nnn) Revenue Form 31A020, "Office of Field Operations Request for Copy of Tax Return(s)", July 2006;

(ooo) Revenue Form 31A050, "Electronic Transmittal Authorization", March 2011;

(ppp) Revenue Form 31A110, "Office of Field Operations Estimated/Jeopardy Assessment", June 2012;

(qqq) Revenue Form 31A114, "Property Audit Request", November 2011;

(rrr) Revenue Form 31A115, "Agreement Fixing Test Periods", April 2008;

(sss) Revenue Form 31A149, "Agreement Fixing Period of Limitation Upon Assessment of Sales, Use or Severance Tax", July 2006;

(ttt) Revenue Form 31A150, "Agreement Fixing Period of Limitation Upon Assessment of Utility Gross Receipts License Tax", May 2008;

(uuu) Revenue Form 31A151, "Agreement Fixing Period of Limitation Upon Assessment of Sales or Use For Authorized EDP Holders", June 2013;

(vvv) Revenue Form 31A200, "Reporting Agreement", November 2011;

(www)~~[vvv]~~ Revenue Form 31A685, "Authorization to

Examine Bank Records", May 1985;
(xxx)(www) Revenue Form 31A800, "IIT Review History Document", November 2011;
(yyv)(xxx) Revenue Form 31A725, "Statute of Limitations Agreement", July 2006;
(zzz)(yyv) Revenue Form 31F006, "Southeastern States Information Exchange Program", March 2012; and
(aaaa)(zzz) Revenue Form 31F010, "Kentucky's Computer Assisted Audit Program", May 2010.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40620, or at any Kentucky Department of Revenue Taxpayer Service Center, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 from 10:00 a.m. to 12:00 p.m., in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 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 February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Department of Revenue, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9826, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order for the Department of Revenue to meet the requirements of KRS 13A.110 which requires that forms required to be submitted by a regulated entity shall be included in an administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation incorporates by reference the required revenue forms used in the general administration of taxes by the Department of Revenue and not limited to a specific tax.

(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 corrects the existing regulation to add new or update existing Department of Revenue forms.

(b) The necessity of the amendment to this administrative regulation: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. Any addition of new forms or a change to existing forms must result in an amendment of the associated regulation to keep it current.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of the tax laws.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide taxpayers with the current version of the forms listed herein.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All Kentucky taxpayers and their representatives will be affected by the listing of all forms administered by the Department of Revenue in an administrative regulation. Local government will be affected to the extent they utilize forms administered by the Department of Revenue. The Department of Revenue will be affected to the extent that it administers the referenced forms.

(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 will have to be taken by the taxpayers or local governments to comply with 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): There would be no cost incurred by the taxpayer or local government.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Access to current forms and instructions will enable taxpayers to comply with tax laws.

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

(a) Initially: The Department of Revenue will not incur additional costs as the result of this regulation.

(b) On a continuing basis: The Department of Revenue will not incur additional costs as the result of this regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Department of Revenue agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: This administrative regulation does not require an increase in fees or funding.

(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 either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied because the requirements of this regulation apply to every taxpayer.

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 Revenue within the Finance and Administration Cabinet.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 131.130(3).

(3) Estimate the effect of this administrative regulation on the

expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No additional cost.

(d) How much will it cost to administer this program for subsequent years? No additional 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:

**FINANCE AND ADMINISTRATION CABINET
Department of Revenue
Office of Sales and Excise Taxes
(Amendment)**

103 KAR 3:020. Sales and Telecommunications Forms Manual.

RELATES TO: KRS 61.870-61.884, 131.010-131.130, 131.150-131.240, 134.580, 136.600-136.660, 139.010-139.795, 144.132, 144.137, 154.20-206, 160.613-160.617, 224.01-310, 247.920

STATUTORY AUTHORITY: KRS 131.130(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue Forms used in the administration of Sales and Use Taxes and Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

Section 1. Sales and Use Tax - Required Forms. (1) Revenue Form 51A101(a), Sales and Use Tax Permit, shall be conspicuously displayed by the sales and use tax permit holder at the location for which the permit was issued.

(2) Revenue Form 51A101(b), Sales and Use Tax Permit Update, shall be issued by the Department of Revenue to update the Sales and Use Tax Permit with business name and address change information.

(3) Revenue Form 51A101(c)(1), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit, shall be issued to Model 1 Streamlined Sales and Use Tax filers registered in Kentucky and shall be conspicuously displayed by the SST permit holder at the location for which the permit was issued.

(4) Revenue Form 51A101(c)(2), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit, shall be issued to Model 2 Streamlined Sales and Use Tax filers registered in Kentucky and shall be conspicuously displayed by the SST permit holder at the location for which the permit was issued.

(5) Revenue Form 51A101(c)(4), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit, shall be issued to Model 4 Streamlined Sales and Use Tax filers registered in Kentucky and shall be conspicuously displayed by the SST permit holder at the location for which the permit was issued.

(6) Revenue Form 51A101(d), Sales and Use Tax Permit Update (SST), shall be issued by the Department of Revenue to update the Kentucky Streamlined Sales and Use Tax (SST) Filing Permit with business name and address change information.

(7) Revenue Form 51A102, Kentucky Sales and Use Tax Worksheet, shall be submitted to the Department of Revenue by a Kentucky sales and use tax permit holder to report total receipts, itemized deductions, amount subject to Kentucky use tax and total amount of Kentucky sales and use tax due for a particular reporting period.

(8) Revenue Form 51A102E, Kentucky Sales and Use Tax Worksheet - Electronic Funds Transfer, shall be submitted to the Department of Revenue by a Kentucky sales and use tax permit holder who remits payment via electronic funds transfer to report total receipts, itemized deductions, amount subject to Kentucky use tax and total amount of Kentucky sales and use tax due for a particular reporting period.

(9) Revenue Form 51A103, Kentucky Accelerated Sales and Use Tax Worksheet, shall be completed by a Kentucky sales and use tax permit holder who has been designated as an accelerated filer to report total receipts, itemized deductions, amount subject to use tax, and total amount of sales and use tax due.

(10) Revenue Form 51A103E, Kentucky Accelerated Sales and Use Tax Worksheet - Electronic Funds Transfer, shall be submitted on a monthly basis by a Kentucky sales and use tax permit holder to report total receipts, itemized deductions, amount subject to use tax, and total amount of sales and use tax due on an accelerated basis and remitted via electronic funds transfer.

(11) Revenue Form 51A105, Resale Certificate, shall be presented to a seller by a Kentucky sales and use tax permit holder to claim that the tangible personal property or digital property purchased from the seller will be:

(a) Resold in the regular course of business;

(b) Leased or rented; or

(c) Used as raw material, industrial supply or industrial tool.

(12) Revenue Form 51A109, Application for Energy Direct Pay Authorization (Sales and Use Tax and Utility Gross Receipts License Tax), shall be filed with the Department of Revenue by a manufacturer, processor, miner or refiner to apply for an energy direct pay authorization.

(13) Revenue Form 51A110, Direct Pay Authorization, shall be presented to a Kentucky sales and use tax permit holder by a company authorized to report and pay directly to the Department of Revenue the sales or use tax on all purchases of tangible personal property, or digital property excluding energy and energy-producing fuels.

(14) Revenue Form 51A111, Certificate of Exemption Machinery for New and Expanded Industry, shall be presented to a Kentucky sales and use tax permit holder by a manufacturer or production processor to claim exemption from sales and use tax.

(15) Revenue Form 51A112, Application for Direct Pay Authorization, shall be submitted by a registered sales and use tax permit holder wishing to obtain a direct pay authorization.

(16) Revenue Form 51A113, Kentucky Consumer's Use Tax Worksheet, shall be completed by a registered consumer's use tax permit holder and submitted to the Department of Revenue on a regular basis to report the amount of purchases of tangible personal property or digital property subject to Kentucky use tax.

(17) Revenue Form 51A113(O), Consumer's Use Tax Return, shall be completed by a person storing, using, or otherwise consuming tangible personal property or digital property in Kentucky who is not registered for a consumer's use tax permit number.

(18) Revenue Form 51A115, Order for Selected Sales and Use Tax Publications, shall be presented to the Department of Revenue by anyone who wishes to order selected sales and use tax forms and regulations.

(19) Revenue Form 51A116, Use Tax Compliance Inquiry Worksheet, shall be completed by a purchaser of Watercraft, Aircraft, or other tangible or digital property to document if the purchase of the property is subject to the Kentucky Use Tax.

(20) Revenue Form 51A125, Application for Purchase Exemption Sales and Use Tax, shall be presented to the Department of Revenue by a resident 501C(3) charitable, educational, or religious institution; historical sites; and units of federal, state or local governments to apply for a sales and use tax exemption on purchases of tangible personal property, digital

property, or certain services to be utilized in the exempt entity's function.

(21) Revenue Form 51A126, Purchase Exemption Certificate, shall be presented to a retailer by a resident charitable, educational or religious institution or Kentucky historical site to claim exemption from sales and use tax on purchases of tangible personal property, digital property, or services.

(22) Revenue Form 51A127, Out-of-State Purchase Exemption Certificate, shall be presented to a retailer by an out-of-state agency or institution that is qualified for exemption in their state of residence.

(23) Revenue Form 51A128, Solid Waste Recycling Machinery Exemption Certificate, shall be presented to a retailer by a business or organization that claims exemption from sales and use tax on the purchase, lease or rental of machinery or equipment to be primarily used for recycling purposes to collect, source separate, compress, bale, shred or otherwise handle waste material.

(24) Revenue Form 51A129, Kentucky Sales and Use Tax Energy Exemption Annual Return, shall be submitted to the Department of Revenue by an energy direct pay holder to reconcile the actual amount of sales and use tax due on purchases of energy and energy-producing fuels to the total amount of sales and use tax paid based upon previous estimates of tax due.

(25) Revenue Form 51A130, Kentucky Sales and Use Tax Monthly Aviation Fuel Tax Credit Schedule of Qualified Certificated Air Carriers, shall be completed by a qualified certificated air carrier on a monthly basis to claim an aviation fuel tax credit against the company's sales and use tax liability for the month.

(26) Revenue Form 51A131, Kentucky Sales and Use Tax Monthly Aviation Fuel Dealer Supplementary Schedule, shall be completed by aviation fuel dealers selling aviation fuel in order to determine the sales and use tax collected and remitted on the sale of aviation fuel, including jet fuel.

(27) Revenue Form 51A132, Kentucky Sales and Use Tax Equine Breeders Supplementary Schedule, shall be completed by an equine breeder to report taxable receipts from equine breeding fees.

(28) Revenue Form 51A135, Kentucky Sales Tax Motor Vehicle Sales Supplementary Schedule, shall be completed by motor vehicle dealers who collect Kentucky sales tax on the sale of motor vehicles to residents of states who subject Kentucky residents to sales upon the purchase of motor vehicles in their states.

(29) Revenue Form 51A143, Purchase Exemption Certificate - Watercraft Industry, shall be presented to a retailer by a purchaser to claim exemption from sales and use tax on the purchase of tangible personal property that will be used for the direct operation of watercraft in the activity of transporting property or in conveying persons for hire.

(30) Revenue Form 51A149, Certificate of Exemption for Pollution Control Facilities, shall be presented to a retailer by a holder of a pollution control tax exemption certificate or jointly by a contractor and the holder of a pollution control tax exemption certificate to claim exemption from sales and use tax on the purchase of materials and equipment that will become part of a certified pollution control facility.

(31) Revenue Form 51A150, Aircraft Exemption Certificate, shall be presented to a retailer by a purchaser to claim exemption from sales and use tax on the purchase of aircraft, repair and replacement parts for the aircraft, and supplies that will be used for the direct operation of aircraft in interstate commerce and used exclusively for the conveyance of property or passengers for hire.

(32) Revenue Form 51A154, Certificate of Exemption Out-of-State Delivery for Aircraft, All Terrain Vehicle (ATV), Mobile/Manufactured Homes, Campers, Boats, Motors or Trailers, shall be completed in triplicate by the seller and buyer when the sale of the tangible personal property occurs and the seller makes delivery of the tangible personal property out of state, and also completes the affidavit portion of the form within two (2) days of the time of delivery to claim that the property was purchased exempt from sales tax and delivered immediately out of state not to return to Kentucky for use.

(33) Revenue Form 51A157, Certificate of Exemption - Water Used in Raising Equine, shall be presented to a retailer by a person regularly engaged in raising equine as a business to claim exemption for the purchase of water used to raise equine.

(34) Revenue Form 51A158, Farm Exemption Certificate, shall be presented to a retailer by a person regularly engaged in the occupation of tilling and cultivating the soil for the production of crops, raising and feeding livestock or poultry; or raising and feeding llamas, alpacas, ratites, buffalo, aquatic organisms, or cervids to claim exemption from sales and use tax on the purchase of certain tangible personal property.

(35) Revenue Form 51A159, On-Farm Facilities Certificate of Exemption for Materials, Machinery and Equipment, shall be presented to a retailer by a farmer or jointly by a farmer and a contractor to claim exemption from sales and use tax on the purchase of materials, machinery and equipment which will be incorporated into the construction, repair, or renovation of on-farm facilities exempt under the provisions of KRS 139.480.

(36) Revenue Form 51A160, Application for Truck Part Direct Pay Authorization, shall be filed with the Department of Revenue by the owner of a motor vehicle, including a towed unit, qualifying for the repair and replacement part exemption provided under KRS 139.480(32)(a) to apply for the truck part direct pay authorization.

(37) Revenue Form 51A161, Truck Part Direct Pay Authorization, shall be issued by the Department of Revenue to authorize motor carriers to report and pay directly to the department the sales and use tax on all purchases of repair and replacement parts for motor vehicles and to authorize retailers to sell motor vehicle repair and replacement parts directly to the authorized motor carrier without receipt of sales and use tax.

(38) Revenue Form 51A163, Application for Charter Bus Part Direct Pay Authorization, shall be filed with the Department of Revenue by the owner of a charter bus qualifying for the repair and replacement part exemption provided under KRS 139.480(32)(b) to apply for a charter bus direct pay authorization.

(39) Revenue Form 51A164, Charter Bus Direct Pay Authorization, shall be issued by the Department of Revenue to authorize charter bus carriers to report and pay directly to the Department the sales and use tax on all purchases of repair and replacement parts for charter buses, and to authorize retailers to sell charter bus repair and replacement parts directly to the charter bus carriers without receipt of sales and use tax.

(40) Revenue Form 51A200, Application for Kentucky Enterprise Initiative Act (KEIA) Tax Refund Program, shall be used by qualified businesses to apply for a refund of sales and use tax paid on purchases of materials used in an approved project.

(41) Revenue Form 51A205, Kentucky Sales and Use Tax Instructions, shall be used by Kentucky sales and use tax permit holders as a guide in filing their sales and use tax returns and maintaining permit account information.

(42) Revenue Form 51A209, Sales and Use Tax Refund Application, shall be completed by a Kentucky sales and use tax permit holder and submitted to the Department of Revenue within four (4) years from the date the tax was paid to apply for a refund of sales and use tax previously paid by the permit holder.

(43) Revenue Form 51A216, Application for Pollution Control Tax Exemption Certificate, shall be completed by a business, governmental unit or institution to apply for a sales and use tax exemption on purchases of tangible personal property used to control or abate pollution.

(44) Revenue Form 51A222, Certificate of Exemption for Alcohol Production Facilities, shall be presented to a retailer by a holder of an alcohol production tax exemption certificate or jointly by a contractor and the holder of an alcohol production tax exemption certificate to claim exemption from sales and use tax on materials and equipment that will become a part of an alcohol production facility as provided by KRS Chapter 247.

(45) Revenue Form 51A223, Application for Alcohol Production Facility Tax Exemption Certificate, shall be completed by a business seeking exemption from sales and use tax on the purchase of materials and equipment that will become a part of an alcohol production facility as provided by KRS Chapter 247.

(46) Revenue Form 51A226, Pollution Control Tax Exemption

Certificate, shall be issued by the Department of Revenue to a business who has qualified for certain sales and use tax, corporation income, corporation license, and property tax benefits.

(47) Revenue Form 51A227, Certificate of Resale (Schools), shall be issued to a retailer by an exempt nonprofit elementary or secondary school or the organizations they sponsor or that are affiliated with them to claim an exemption from sales and use tax on the purchase of tangible personal property or digital property that will be resold if the proceeds from the resale of the property is used solely for the benefit of the elementary or secondary schools or their students.

(48) Revenue Form 51A228, Application for Fluidized Bed Combustion Technology Tax Exemption Certificate, shall be completed by a business, governmental unit or organization and submitted to the Department of Revenue to apply for a sales and use tax exemption on the purchase of equipment and materials used in fluidized bed combustion technology.

(49) Revenue Form 51A229, Fluidized Bed Combustion Technology Tax Exemption Certificate, shall be issued by the Department of Revenue to a business, governmental unit or organization to advise that they qualify for corporation license tax, property tax, and sales and use tax benefits.

(50) Revenue Form 51A241, Registration for the Kentucky Sales and Use Tax Refund for Motion Picture and Television Production Companies, shall be completed by a motion picture production company and submitted to the Department of Revenue to register for a sales and use tax refund.

(51) Revenue Form 51A242, Application for Sales and Use Tax Refund for Motion Picture Production Company, shall be completed by a registered motion picture production company and submitted to the Department of Revenue within sixty (60) days after completion of the filming or production of the motion picture in Kentucky to request a refund of the Kentucky sales and use tax paid on purchases of tangible personal property or digital property made in connection with filming and producing motion pictures in Kentucky.

(52) Revenue Form 51A250, Application for Transient Merchant Permit, shall be completed by a transient merchant and filed with the clerk in the county in which the business is to be conducted, or if an urban county government, with the officer of the government who has responsibility for the issuance of business permits and licenses to obtain a permit before conducting any business in Kentucky.

(53) Revenue Form 51A260, Streamlined Sales and Use Tax Agreement-Certificate of Exemption, shall be presented to a seller by a purchaser to claim that tangible personal property, digital property, or certain services purchased from the seller qualifies for exemption.

(54) Revenue Form 51A270, Certificate of Sales Tax Paid on the Purchase of a Motor Vehicle, shall be issued by motor vehicle dealers to a non-resident purchaser of a motor vehicle on which the Kentucky sales tax has been paid.

(55) Revenue Form 51A280, Out-Of-State Purchase-Use Tax Affidavit, shall be submitted to the county clerk by a taxpayer purchasing tangible personal property from out-of-state for title or first-time registration.

(56) Revenue Form 51A290, Information Sharing and Assignment Agreement for Designated Refund Claims, shall be submitted by an approved company or agency and its vendors and contractors who agree to share documentation with the Department of Revenue for refund claim under the Kentucky Enterprise Initiative Act, Signature Project, or Alternative Fuel, Gasification or Renewable Energy Facility.

(57) Revenue Form 51A291, Application for Kentucky Signature Project Sales and Use Tax Refund, shall be completed by an approved company or agency in the construction of an approved Signature Project submitted to the Department of Revenue annually during the twelve (12) years the project grant agreement is in effect.

(58) Revenue Form 51A292, Expenditure Report for Signature Project Refunds, shall be submitted by a refund applicant to document expenditures and taxes paid on property and materials used in the construction of an approved Signature Project.

(59) Revenue Form 51A300, Application for Preapproval for Energy Efficiency Machinery or Equipment, shall be submitted by a person engaged in manufacturing for preapproval for purchase of new or replacement machinery or equipment that reduces the consumption of energy or energy producing fuels by at least fifteen (15) percent.

(60) Revenue Form 51A301, Application for Kentucky Alternative Fuel, Gasification, and Renewable Energy Facility Sales and Use Tax Refund, shall be submitted by a refund applicant to request refund of sales and use tax paid on purchases of building and construction materials purchased and used in the construction of an approved Alternative Fuel, Gasification, or Renewable Facility.

(61) Revenue Form 51A302, Expenditure Report for Alternative Fuel, Gasification, & Renewable Energy Facility Refunds, shall be submitted by a refund applicant to document expenditures and taxes paid on property and materials used in the construction of an approved Alternative Fuel, Gasification, or Renewable Energy Facility.

(62) Revenue Form 51A350, Information Sharing and Assignment Agreement for Energy Efficiency Project Incentive, shall be submitted by an approved company or agency and its vendors and contractors who agree to share documentation with the Department of Revenue for refund claims on construction of an approved Alternative Fuel, Gasification, or Renewable Energy Facility.

(63) Revenue Form 51A351, Application for Energy Efficiency Machinery or Equipment Sales and Use Tax Incentive, shall be submitted by a refund applicant to request refund of sales and use tax paid on purchases of approved energy-efficiency machinery or equipment used at a manufacturing plant.

(64) Revenue Form 51A400, Governmental Public Facility Sales Tax Rebate Registration, shall be completed by the public facility to determine eligibility for the sales tax rebate under KRS 139.533.

(65) Revenue Form 51A401, Governmental Public Facility Application for Sales Tax Rebate, shall be completed by the public facility to request a sales tax rebate. It includes a list of vendors and tax amounts claimed in the rebate request as well as banking information if an electronic fund transfer is requested by the public facility.

(66) Revenue Form 51A402, Vendor Assignment Agreement for Sales at a Qualifying Public Facility, shall be properly executed for any seller, other than the qualifying governmental entity whose receipts are included in the rebate request.

(67) Revenue Form 51A600, Application for Kentucky Disaster Relief, Sales and Use Tax Refund, shall be completed by the legal building owner to request a sales and use tax refund.

(68) Revenue Form 51A601, Information Sharing and Assignment Agreement for Disaster Relief Refund Claims, shall be completed by the legal building owner and other related parties to ensure compliance with taxpayer confidentiality laws (KRS 131.190, 131.081(15), 131.990).

(69) Revenue Form 51A602, Expenditure Report for Building Materials Disaster Relief Funds, shall be completed by the legal building owner detailing all building materials purchased to repair or replace a building in a disaster area and the total corresponding Kentucky sales and use tax paid and submitted to the Department of Revenue.

(70) Revenue Form 51F008, Federal Government Exemption from Kentucky Sales and Use Tax, shall be issued by the Department of Revenue to a federal government unit which in turn is presented to a retailer by the federal government unit to claim exemption from sales and use tax on purchases of property to be used in the exempt governmental function.

(71) ~~(69)~~ Revenue Form 51F009, Purchase Exemption Notification, shall be issued by the Department of Revenue to a resident nonprofit charitable, educational or religious institution to advise the entity of the assigned purchase exemption number and additional information concerning the exemption from sales and use tax.

(72) ~~(69)~~ Revenue Form 51F010, Energy Direct Pay Authorization, shall be issued by the Department of Revenue to

advise a Kentucky sales and use tax permit holder that it has been authorized to purchase energy and energy-producing fuels without paying or reimbursing the vendor for the sales and use tax and that they are required to report and pay directly to the Department of Revenue the sales and use tax on that portion of the cost price which is subject to tax pursuant to KRS 139.480(3).

~~(73)~~~~(70)~~ Revenue Form 51F010(a), Utility Gross Receipts License Tax (UGRLT) Exemption Authorization, shall be issued by the Department of Revenue to advise a Kentucky sales and use tax permit holder that it has been authorized to purchase energy and energy-producing fuels without paying or reimbursing the vendor for the utility gross receipts license tax and that they are required to report and pay directly to the Department of Revenue the utility gross receipts license tax on that portion of the purchase price which is subject to tax.

~~(74)~~~~(71)~~ Revenue Form 51F010(b), Energy Direct Pay - Utility Gross Receipts License Tax Exemption Authorization, shall be issued by the Department of Revenue to advise a Kentucky sales and use tax permit holder that it has been authorized to purchase energy and energy-producing fuels without paying or reimbursing the vendor for either the sales and use tax or the utility gross receipts license tax and that they are required to report and pay directly to the Department of Revenue the sales and use tax and the utility gross receipts license tax on that portion of the purchase price which is subject to tax.

Section 2. Telecommunications Provider Tax - Required Forms. (1) Revenue Form 75A001, Telecommunications Tax Receipts Certification Form, shall be used by city and county taxing jurisdictions to certify tax receipts for prior fiscal year if applicable.

(2) Revenue Form 75A002, Telecommunications Provider Tax Return, shall be used by telecommunications providers to report gross revenues subject to the excise tax and gross revenues tax, and by consumers to report retail purchases of multi-channel video programming services to report the tax due.

(3) Revenue Form 75A002 (I), Instructions for Telecommunications Provider Tax Return, shall be used by telecommunications providers as a guide in filing their telecommunications provider tax return.

(4) Revenue Form 75A005, Telecommunications Tax Complaint Form, shall be submitted to the Department of Revenue by local taxing authorities who express disagreement with the distribution of telecommunications tax to their jurisdiction.

(5) Revenue Form 75A900, Telecommunications Tax Application, shall be used by telecommunications providers to register with the Department of Revenue.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Sales and use tax - referenced material:

1. Revenue Form 51A101(a), "Sales and Use Tax Permit", August 2011;
2. Revenue Form 51A101(b), "Sales and Use Tax Permit Update", August 2011;
3. Revenue Form 51A101(c)(1), "Kentucky Streamlined Sales and Use Tax (SST) Filing Permit", August 2008;
4. Revenue Form 51A101(c)(2), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit", August 2008;
5. Revenue Form 51A101(c)(4), Kentucky Streamlined Sales and Use Tax (SST) Filing Permit", August 2008;
6. Revenue Form 51A101(d), "Sales and Use Tax Permit Update (SST)", August 2011;
7. Revenue Form 51A102, "Kentucky Sales and Use Tax Worksheet", January 2012~~[2010]~~;
8. Revenue Form 51A102E, "Kentucky Sales and Use Tax Worksheet - Electronic Funds Transfer", January 2012~~[2010]~~;
9. Revenue Form 51A103, "Kentucky Accelerated Sales and Use Tax Worksheet", January 2012~~[2010]~~;
10. Revenue Form 51A103E, "Kentucky Accelerated Sales and Use Tax Worksheet - Electronic Funds Transfer", January 2010;
11. Revenue Form 51A105, "Resale Certificate", December 2009;
12. Revenue Form 51A109, "Application for Energy Direct Pay

Authorization (Sales and Use Tax and Utility Gross Receipts License Tax)", February 2011;

13. Revenue Form 51A110, "Direct Pay Authorization", April 2011;

14. Revenue Form 51A111, "Certificate of Exemption Machinery for New and Expanded Industry", August 2011;

15. Revenue Form 51A112, "Application for Direct Pay Authorization", December 2009;

16. Revenue Form 51A113, "Kentucky Consumer's Use Tax Worksheet", January 2010;

17. Revenue Form 51A113(O), "Consumer's Use Tax Return", December 2009;

18. Revenue Form 51A115, "Order for Selected Sales and Use Tax Publications", April 2011;

19. Revenue Form 51A116, "Use Tax Compliance Inquiry Worksheet", March 2008;

20. Revenue Form 51A125, "Application for Purchase Exemption Sales and Use Tax", December 2009;

21. Revenue Form 51A126, "Purchase Exemption Certificate", December 2009;

22. Revenue Form 51A127, "Out-of-State Purchase Exemption Certificate", December 2009;

23. Revenue Form 51A128, "Solid Waste Recycling Machinery Exemption Certificate", March 2005;

24. Revenue Form 51A129, "Kentucky Sales and Use Tax Energy Exemption Annual Return", February 2011;

25. Revenue Form 51A130, "Kentucky Sales and Use Tax Monthly Aviation Fuel Tax Credit Schedule of Qualified Certificated Air Carriers", August 2005;

26. Revenue Form 51A131, "Kentucky Sales and Use Tax Monthly Aviation Fuel Dealer Supplementary Schedule", August 2008;

27. Revenue Form 51A132, "Kentucky Sales and Use Tax Equine Breeders Supplementary Schedule", June 2005;

28. Revenue Form 51A135, "Kentucky Sales Tax Motor Vehicle Sales Supplementary Schedule", August 2006;

29. Revenue Form 51A143, "Purchase Exemption Certificate - Watercraft Industry", March 2005;

30. Revenue Form 51A149, "Certificate of Exemption for Pollution Control Facilities", January 2007;

31. Revenue Form 51A150, "Aircraft Exemption Certificate", January 2005;

32. Revenue Form 51A154, "Certificate of Exemption Out-of-State Delivery for Aircraft, All Terrain Vehicle (ATV), Mobile/Manufactured Homes, Campers, Boats, Motors or Trailers", January 2005;

33. Revenue Form 51A157, "Certificate of Exemption - Water Used in Raising Equine", July 2005;

34. Revenue Form 51A158, "Farm Exemption Certificate", July 2008;

35. Revenue Form 51A159, "On-Farm Facilities Certificate of Exemption for Materials, Machinery and Equipment", July 2008;

36. Revenue Form 51A160, "Application for Truck Part Direct Pay Authorization", March 2005;

37. Revenue Form 51A161, "Truck Part Direct Pay Authorization", December 2006;

38. Revenue Form 51A163, "Application for Charter Bus Part Direct Pay Authorization", June 2005;

39. Revenue Form 51A164, "Charter Bus Direct Pay Authorization", August 2006;

40. Revenue Form 51A200, "Application for Kentucky Enterprise Initiative Act (KEIA) Tax Refund Program", March 2008;

41. Revenue Form 51A205, "Kentucky Sales and Use Tax Instructions", July 2008;

42. Revenue Form 51A209, "Sales and Use Tax Refund Application", May 2007;

43. Revenue Form 51A216, "Application for Pollution Control Tax Exemption Certificate", March 2005;

44. Revenue Form 51A222, "Certificate of Exemption for Alcohol Production Facilities", August 2011;

45. Revenue Form 51A223, "Application for Alcohol Production Facility Tax Exemption Certificate", July 1980;

46. Revenue Form 51A226, "Pollution Control Tax Exemption

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Certificate", March 2005;

47. Revenue Form 51A227, "Certificate of Resale (Schools)", May 2007;

48. Revenue Form 51A228, "Application for Fluidized Bed Combustion Technology Tax Exemption Certificate", May 2007;

49. Revenue Form 51A229, "Fluidized Bed Combustion Technology Tax Exemption Certificate", August 2011;

50. Revenue Form 51A241, "Registration for the Kentucky Sales and Use Tax Refund for Motion Picture and Television Production Companies", May 2007;

51. Revenue Form 51A242, "Application for Sales and Use Tax Refund for Motion Picture Production Company", May 2007;

52. Revenue Form 51A250, "Application for Transient Merchant Permit", April, 2005;

53. Revenue Form 51A260, "Streamlined Sales and Use Tax Agreement - Certificate of Exemption", January 2012~~February 2010~~;

54. Revenue Form 51A270, "Certificate of Sales Tax Paid on the Purchase of a Motor Vehicle", August 2006;

55. Revenue Form 51A280, "Out-Of-State Purchase-Use Tax Affidavit", July 2009;

56. Revenue Form 51A290, "Information Sharing and Assignment Agreement for Designated Refund Claims", October 2007;

57. Revenue Form 51A291, "Application for Kentucky Signature Project Sales and Use Tax Refund", April 2011;

58. Revenue Form 51A292, "Expenditure Report for Signature Project Refunds", October 2007;

59. Revenue Form 51A300, "Application for Preapproval for Energy Efficiency Machinery or Equipment", June 2008;

60. Revenue Form 51A301, "Application for Kentucky Alternative Fuel, Gasification, and Renewable Energy Facility Sales and Use Tax Refund", April 2011;

61. Revenue Form 51A302, "Expenditure Report for Alternative Fuel, Gasification, & Renewable Energy Facility Refunds", December 2008;

62. Revenue Form 51A350, "Information Sharing and Assignment Agreement for Energy Efficiency Project Incentive", June 2008;

63. Revenue Form 51A351, "Application for Energy Efficiency Machinery or Equipment Sales and Use Tax Incentive", April 2011;

64. Revenue Form 51A400, "Governmental Public Facility Sales Tax Rebate Registration", June 2010;

65. Revenue Form 51A401, "Governmental Public Facility Application for Sales Tax Rebate", June 2010;

66. Revenue Form 51A402, "Vendor Assignment Agreement for Sales at a Qualifying Public Facility", June 2010;

67. Revenue Form 51A600, "Application for Kentucky Disaster Relief Sales and Use Tax Refund", April 2012;

68. Revenue Form 51A601, "Information Sharing and Assignment Agreement for Disaster Relief Refund Claims", April 2012;

69. Revenue Form 51A602, "Expenditure Report for Building Materials Disaster Relief Refunds", April 2012;

70. Revenue Form 51F008, "Federal Government Exemption from Kentucky Sales and Use Tax", January 2008;

71[68]. Revenue Form 51F009, "Purchase Exemption Notification", January 2008;

72[69]. Revenue Form 51F010, "Energy Direct Pay Authorization", January 2008;

73[70]. Revenue Form 51F010(a), "Utility Gross Receipts License Tax (UGRLT) Exemption Authorization", January 2008; and

74[71]. Revenue Form 51F010(b), "Energy Direct Pay - Utility Gross Receipts License Tax Exemption Authorization", January 2008;

(b) Telecommunications provider tax - referenced material:

1. Revenue Form 75A001, "Telecommunications Tax Receipts Certification Form", December 2005;

2. Revenue Form 75A002, "Telecommunications Provider Tax Return", March 2006;

3. Revenue Form 75A002(l), "Instructions for Telecommunications Provider Tax Return", July 2006;

4. Revenue Form 75A005, "Telecommunications Tax Complaint Form", April 2011; and

5. Revenue Form 75A900, "Telecommunications Tax Application", December 2005.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40620, or at any Kentucky Department of Revenue Taxpayer Service Center, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 from 10:00 a.m. to 12:00 p.m., in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 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 February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Department of Revenue, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9826, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of Sales and Use Tax and Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order for the Department of Revenue to meet the requirements of KRS 13A.110 which requires that forms required to be submitted by a regulated entity shall be included in an administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of the Sales and Use Tax and the Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation incorporates by reference the required revenue forms used in the administration of the Sales and Use Tax and Telecommunications Excise and Gross Revenues Tax by the Department of Revenue.

(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 updated form information.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure that the most

recent versions of forms are referenced.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment incorporates the most recent forms by reference as authorized by KRS 131.130(3).

(d) How the amendment will assist in the effective administration of the statutes: This amendment informs taxpayers of the most recent versions of forms that should be used to file their tax returns.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All Kentucky taxpayers and their representatives will be affected by the listing of forms administered by the Department of Revenue in an administrative regulation. Local government will be affected to the extent they utilize forms administered by the Department of Revenue. The Department of Revenue will be affected to the extent that it administers the referenced forms.

(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 will have to be taken by the taxpayers or local governments to comply with 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): There will be no anticipated cost incurred by the taxpayer or local government.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Taxpayers will be able to reference all sales and use and telecommunications excise and gross revenues tax forms in one location.

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

(a) Initially: The Department of Revenue will not incur additional costs as the result of this regulation.

(b) On a continuing basis: The Department of Revenue will not incur additional costs as the result of this administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Department of Revenue agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new or by the change if it is an amendment: This administrative regulation does not require an increase in fees or funding.

(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 either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied because the requirements of this regulation apply to every taxpayer.

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 Revenue 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 131.130(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. There will be no effect on expenditures or revenue of a state or local government agency as a result of this administrative regulation.

(a) How much revenue will this administrative regulation

generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? 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:

FINANCE AND ADMINISTRATION CABINET Department of Revenue Office of Property Valuation (Amendment)

103 KAR 3:030. Property and Severance Forms manual.

RELATES TO: KRS 42.470, 61.870-61.884, 131.020, 131.030, 131.041-131.081, 131.081(2), (9), (15), 131.110, 131.130, 131.130(3), 131.155, 131.181, 131.183, 131.190, 131.340, 131.500, 131.500(1), (2), (3), (10), 131.510(1), (2)(a), 131.540, 132.020, 132.130-132.180, 132.190, 132.200, 132.220-132.270, 132.290, 132.310, 132.320, 132.360, 132.450, 132.487, 132.510, 132.820, 132.825, 132.990, 133.045, 133.110, 133.120, 133.130, 133.240, 134.015, 134.119, 134.020, 134.121, 134.122, 134.128, 134.129, 134.390, 134.420, 134.430, 134.440, 134.500, 134.590, 134.800, 134.805, 134.810, 134.815, 134.820, 134.825, 134.830, 135.010, 135.020, 135.050, 136.020, 136.050, 136.115-136.180, 136.1802-136.1806, 136.1873, 136.188, 136.310, 136.320, 136.330, 136.335, 136.377, 136.545, 136.575, 136.600-136.660, 137.130, 137.160, 143.030(1), 143.037, 143.040, 143.050, 143.060(1), 143.085, 143.990, 143A.010, 143A.030, 143A.035, 143A.037, 143A.080, 143A.090, 143A.100(1), 143A.991, Ky. Const. Sec. 170

STATUTORY AUTHORITY: KRS 131.130(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue Forms used in the administration of Property and Severance Taxes by the Department of Revenue.

Section 1. Property Tax - Required Forms. (1) Revenue Form 61A200(P), "Property Tax Forms and Instructions for Public Service Companies 2014[2013]", shall be the packet of files and instructions relating to Revenue Form 61A200 for use by public service companies reporting company name, location and other pertinent filing information with the Department of Revenue.

(2) Revenue Form 61A200, "Public Service Company Property Tax Return for Year Ending December 31, 2013[2012]", shall be filed by public service companies reporting company name, location, and other pertinent filing information with the Department of Revenue.

(3) Revenue Form 61A200(A), "Report of Total Unit System and Kentucky Operations", shall be filed by public service companies with the Department of Revenue, reporting the System and Kentucky original cost, total depreciation and depreciated cost for all operating and non-operating property types as of the end of the taxable year.

(4) Revenue Form 61A200(B), "Report of Kentucky Vehicles, Car Lines and Watercraft", shall be filed by public service companies with the Department of Revenue, reporting the assessed value of all Kentucky apportioned and regular licensed

motor vehicles, railroad car lines and commercial watercraft as of the end of the year.

(5) Revenue Form 61A200(C), "Report of Total Unit Operations Balance Sheet", shall be filed by public service companies with the Department of Revenue, reporting a financial statement (balance sheet) as of December 31 for the system operating unit including Kentucky.

(6) Revenue Form 61A200(D), "Report of Total Unit Operations Income Statement", shall be filed by public service companies with the Department of Revenue, reporting a financial statement (income statement) for twelve (12) months ending December 31 for the system operating unit including Kentucky.

(7) Revenue Form 61A200(E), "Filing Extension Application", shall be used by public service companies to request an extension of time to file the public service company tax return.

(8) Revenue Form 61A200(G), "Report of Capital Stocks", shall be filed by public service companies with the Department of Revenue, reporting an analysis of their capital stocks as of the end of the taxable year.

(9) Revenue Form 61A200(H), "Report of Funded Debt", shall be filed by public service companies with the Department of Revenue reporting an analysis of their debt as of the end of the taxable year.

(10) Revenue Form 61A200(I), "Business Summary by Taxing Jurisdiction", shall be filed by public service companies with the Department of Revenue, reporting a summary of the business activity within each taxing district.

(11) Revenue Form 61A200(J), "Property Summary by Taxing Jurisdiction, Operating and Nonoperating Property", shall be filed by public service companies with the Department of Revenue reporting a summary of the amount of operating and nonoperating property owned or leased in this state, by each county, city and special district.

(12) Revenue Form 61A200(K), "Operating Property Listing by Taxing Jurisdiction", shall be filed by public service companies with the Department of Revenue, reporting an inventory of the amount and kind of operating property, owned or leased, located in this state, for each county, city and special taxing district.

(13) Revenue Form 61A200(K2), "Nonoperating/Nonutility Property Listing by Taxing Jurisdiction", shall be filed by public service companies with the Department of Revenue reporting an inventory of the amount and kind of nonoperating property owned or leased, located in this state, for each county, city and special taxing district.

(14) Revenue Form 61A200(L), "Report of Allocation Factors, Operating and Noncarrier Property for All Interstate Companies", shall be filed by interstate, noncarrier, public service companies with the Department of Revenue, reporting property and business factors in total and for the state of Kentucky.

(15) Revenue Form 61A200(M), "Report of Property and Business Factors for Interstate Railroad and Sleeping Car Companies", shall be filed by interstate railroad and sleeping car companies with the Department of Revenue, reporting property and business factors in total and for the state of Kentucky.

(16) Revenue Form 61A200(N1), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", shall be filed by public service companies with the Department of Revenue, reporting all leased real property and the terms of the lease by taxing district.

(17) Revenue Form 61A200(N2), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", shall be filed by public service companies with the Department of Revenue, reporting all leased personal property and the terms of the lease by taxing district.

(18) Revenue Form 61A200(N3), "Summary Report of System and Kentucky Operating Lease Payments", shall be filed by public service companies with the Department of Revenue reporting the annual operating lease payments paid during the calendar year.

(19) Revenue Form 61A200(O), "Railroad Private Car Mileage Report", shall be filed by railroad car line companies with the Department of Revenue reporting the name and address of the company and the mileage in Kentucky.

(20) Revenue Form 61A200(Q), "Supplemental Report of

Operations for Contained and Residential Landfills", shall be filed by landfills with the Department of Revenue, reporting historic, current, and projected operational information.

(21) Revenue Form 61A200(R), "Report of Property Subject to the Pollution Control Tax Exemption", shall be filed by public service companies with the Department of Revenue, reporting certified pollution control equipment, the original cost and the net book value.

(22) Revenue Form 61A200(U), "Industrial Revenue Bond Property", shall be filed by a public service company to list real and tangible personal property purchased with an industrial revenue bond.

(23) Revenue Form 61A202, "2014[2013] Public Service Company Property Tax Return for Railroad Car Line", shall be filed by railroad car line companies with the Department of Revenue, classifying the railcars by type and reporting cost, age, and mileage for each railcar.

(24) Revenue Form 61A206(P), "Public Service Company Property Tax Forms and Instructions for Commercial Air Passenger and Air Freight Carriers 2014[2013]", shall be the packet of files and instructions relating to Revenue Form 61A206 for use by commercial air passenger and air freight carriers reporting company name, location and other pertinent information with the Department of Revenue.

(25) Revenue Form 61A206, "Public Service Company Property Tax Return For Commercial Air Passenger and Air Freight Carriers", shall be filed by all commercial air passenger and air freight carriers reporting taxpayer name, location and other pertinent information with the Department of Revenue.

(26) Revenue Form 61A206(A), "Filing Extension Application for Public Service Company Property Tax Return", shall be used by commercial air passenger and air freight carriers to request an extension of time to file the commercial air passenger and air freight carriers tax return.

(27) Revenue Form 61A206(B), "Report of Kentucky Registered and Licensed Motor Vehicles", shall be filed by commercial air passenger and air freight carriers to report vehicles, both owned and leased, registered within the state of Kentucky as of December 31.

(28) Revenue Form 61A206(C), "Report of Financial Operations for Commercial Air Passenger and Air Freight Carriers", shall be used by all commercial, passenger or cargo airlines conducting business in Kentucky to provide the Department of Revenue with year-end financial statements, a complete annual report, and a complete 10K report (FCC annual report) for the twelve (12) month period ending December 31.

(29) Revenue Form 61A206(D-1), "Report of System Aircraft Fleet", shall be filed by commercial air passenger and air freight carriers providing a complete listing of fleet aircraft owned and capital-leased as of December 31.

(30) Revenue Form 61A206(D-2), "Report of System Aircraft Fleet", shall be filed by commercial air passenger and air freight carriers providing a complete listing of operating leased fleet aircraft.

(31) Revenue Form 61A206(D-3), "Report of System Aircraft Fleet", shall be filed by all commercial air passenger and air freight carriers providing a complete listing of all fleet managed aircraft and aircraft held for resale or nonoperating.

(32) Revenue Form 61A206(E), "Report of Kentucky Flight Statistics By Airport", shall be filed by all commercial air passenger and air freight carriers providing a listing of all arrivals, departures, and ground time at all Kentucky airports and heliports.

(33) Revenue Form 61A206(F), "Report of System and Kentucky Allocation Factors", shall be filed by all commercial air passenger and air freight carriers listing property factors and business factors.

(34) Revenue Form 61A206(G), "Report of Funded Debt", shall be filed by all commercial air passenger and air freight carriers listing all debt obligations, both long term and short term, by class and obligation.

(35) Revenue Form 61A206(H), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing

all real property in Kentucky leased on an operating lease basis.

(36) Revenue Form 61A206(I), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing all personal property in Kentucky leased on an operating lease basis.

(37) Revenue Form 61A206(J), "Summary Report of System and Kentucky Operating Lease Payments", shall be filed by all commercial air passenger and air freight carriers listing all annual operating lease payments.

(38) Revenue Form 61A206(K), "Report of Owned Real Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing all real property owned in Kentucky.

(39) Revenue Form 61A206(L), "Report of Owned Personal Property Located in Kentucky By Taxing District", shall be filed by all commercial air passenger and air freight carriers listing all personal property owned in Kentucky.

(40) Revenue Form 61A206(M), "Summary Report of Total System and Kentucky Operations", shall be filed by all commercial air passenger and air freight carriers listing all real and personal property owned and leased, providing the original cost, depreciation and depreciated cost values.

(41) Revenue Form 61A206(N), "Industrial Revenue Bond Property", shall be filed by all commercial air passenger and air freight carriers listing real and tangible property purchased with an industrial revenue bond.

(42) Revenue Form 61A206(O), "Public Service Company Sales", shall be filed by commercial air passenger and air freight carriers listing any assets bought or sold during the year.

(43) Revenue Form 61A207(P), "Commercial Watercraft Personal Property Tax Return ~~2014~~[2013]", shall be the packet of files and instructions relating to Revenue Form 61A207 for use by commercial watercraft owners both resident and nonresident, reporting the watercraft's book value, original cost and total and Kentucky route mileage with the Department of Revenue.

(44) Revenue Form 61A207, "~~2014~~[2013] Commercial Watercraft Personal Property Tax Return", shall be filed by all commercial watercraft owners, both resident and nonresident, reporting the watercraft's book value, original cost, and total and Kentucky route mileage with the Department of Revenue.

(45) Revenue Form 61A207(A), "Report of Owned Vessels in Your Possession", shall be filed with the Department of Revenue, reporting all owned vessels (both available and operating) in their fleet as of January 1, ~~2014~~[2013].

(46) Revenue Form 61A207(B), "Report of Owned Vessels - in Possession of Others", shall be filed with the Department of Revenue, reporting all owned vessels that are in possession of other persons, companies, corporations, operators, or charterers as of January 1, ~~2014~~[2013].

(47) Revenue Form 61A207(C), "Report of Nonowned Vessels in Your Possession", shall be filed with the Department of Revenue, reporting all nonowned vessels (both available and operating) in their fleet as of January 1, ~~2014~~[2013].

(48) Revenue Form 61A207(D), "Commercial Watercraft Valuation Worksheet", shall be filed with the Department of Revenue, reporting the original cost, cost of rebuilds and the cost of major improvements of all owned and nonowned vessels.

(49) Revenue Form 61A207(E), "Report of Kentucky Route Miles", shall be filed with the Department of Revenue reporting the system route miles traveled on Kentucky waterways.

(50) Revenue Form 61A207(F), "Report of System Route Miles", shall be filed with the Department of Revenue reporting the system route miles traveled on United States waterways.

(51) Revenue Form 61A209, "Public Service Company Sales", shall be filed by public service companies with the Department of Revenue, reporting any full or partial sale or purchase of assets of the public service company.

(52) Revenue Form 61A211, "Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs", shall be filed by public service companies with the Department of Revenue reporting all motor vehicles owned or leased within Kentucky.

(53) Revenue Form 61A211(I), "Instructions Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs", shall provide instructions for completing Revenue Form 61A211, "Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs".

(54) Revenue Form 61A211(IP), "Instructions For Editing the Public Service Company Motor Vehicle Printout", shall provide instructions for editing the computer printout of previously reported licensed vehicles sent by the Department of Revenue to public service companies that have listed vehicles with the department in prior years.

(55) Revenue Form 61A230, "Notice of Assessment", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the final assessment of the public service company property.

(56)[(55)] Revenue Form 61A240, "Notice of Assessment", shall be sent by the Department of Revenue to the taxpayer notifying him or her of a tentative assessment of the public service company property. This notice shall inform the taxpayer of the protest period.

(57)[(56)] Revenue Form 61A250, "Notice of Assessment", shall be sent by the Department of Revenue to the taxpayer notifying the taxpayer of his or her claim of assessed value on public service company property.

(58)[(57)] Revenue Form 61A255, "Public Service Company Property Tax Statement", shall be used by the counties, schools and special districts to bill public service companies for local property taxes.

(59)[(58)] Revenue Form 61A255(I), "Instructions for 61A255, Public Service Company Property Tax Statement", shall provide instructions for completing Revenue Form 61A255, "Public Service Company Property Tax Statement".

(60)[(59)] Revenue Form 61A500(P), "~~2014~~[2013] Personal Property Tax Forms and Instructions for Communications Service Providers and Multichannel Video Programming Service Providers", shall be the packet of files and instructions relating to Revenue Form 61A500 for use by telecommunication, satellite, and cable television companies, reporting all tangible personal property with the Department of Revenue.

(61)[(60)] Revenue Form 61A500, "~~2014~~[2013] Tangible Personal Property Tax Return for Communications Service Providers and Multichannel Video Programming Service Providers", shall be filed by telecommunications, satellite, and cable television companies, reporting all tangible personal property with the Department of Revenue.

(62)[(61)] Revenue Form 61A500(H), "Report of Total Personal Tangible Property in Kentucky", shall be filed by telecommunication, satellite, and cable television companies with the Department of Revenue, summarizing the Kentucky original cost, depreciation, and net book value of each class of tangible personal property.

(63)[(62)] Revenue Form 61A500(I), "Summary of Gross Personal Tangible Property Listing by Taxing District", shall be filed by telecommunication, satellite, and cable television companies with the Department of Revenue, summarizing the Kentucky Original Cost by taxing jurisdiction.

(64)[(63)] Revenue Form 61A500(J), "Summary of Reported Personal Tangible Property Listing by Taxing District", shall be filed by telecommunication, satellite, and cable television companies with the Department of Revenue, summarizing the Kentucky reported value by taxing jurisdiction.

(65)[(64)] Revenue Form 61A500(K), "Personal Tangible Property Listing by Taxing District", shall be filed by telecommunication, satellite and cable television companies with the Department of Revenue and shall contain an inventory of the amount and kind of personal property owned and located in Kentucky by taxing jurisdiction.

(66)[(65)] Revenue Form 61A508, "Annual Report of Distilled Spirits in Bonded Warehouse", shall be filed by distilleries with the Department of Revenue to report inventory as of January 1.

(67)[(66)] Revenue Form 61A508-S1, "Schedule 1 Department of Property Valuation Cost of Production Schedule", shall be filed by distilleries with the Department of Revenue, reporting the average cost per gallon of production.

~~(68)~~~~(67)~~ Revenue Form 61A508-S2, "Schedule 2 Department of Property Valuation Storage Cost Schedule", shall be filed by distilleries with the Department of Revenue, reporting average per barrel storage cost.

~~(69)~~~~(68)~~ Revenue Form 61A508-S3, "Schedule 3 Schedule of Bulk Sales", shall be filed by distilleries with the Department of Revenue, reporting the date of the sale or purchase, the number of barrels, age, and the price.

~~(70)~~~~(69)~~ Revenue Form 61A508-S4, "Schedule 4", shall be filed by distilleries with the Department of Revenue, reporting the fair cash value of bulk inventory summarized on Form 61A508.

~~(71)~~~~(70)~~ Revenue Form 61A508-S5, "Schedule 5", shall be filed by distilleries with the Department of Revenue, reporting the fair cash values of case goods summarized on Form 61A508.

~~(72)~~ Revenue Form 61A508-S6, "Schedule 6 Industrial Revenue Bond Property", shall be filed with the Department of Revenue, reporting property purchased with an industrial revenue bond.

~~(73)~~~~(71)~~ Revenue Form 61A509, "Distilled Spirits or Telecoms Property Tax Statement", shall be used by county clerks and local tax jurisdictions to bill assessments of distilled spirits and telecom personal property.

~~(74)~~~~(72)~~ Revenue Form 61F007, "Notification Protesting Your Commercial Watercraft Assessment", shall inform taxpayers of the protest procedures on Commercial Watercraft assessments.

~~(75)~~~~(73)~~ Revenue Form 61F008, "Notification Protesting Your Assessment", shall inform taxpayers of the protest procedures on Railroad Car Line assessments.

~~(76)~~~~(74)~~ Revenue Form 61F009, "Notification Protesting Your Assessment", shall inform taxpayers of the protest procedures on Public Service Company Property Tax assessments.

~~(77)~~~~(75)~~ Revenue Form 61F010, "Property Value Assessments for Public Service and Centrally Assessed Companies - Assessment of Distilled Spirits in Bonded Warehouses", shall inform taxpayers of the protest procedures on Distilled Spirits assessments.

~~(78)~~~~(76)~~ Revenue Form 62A007, "Motor Vehicle Tax and/or Registration Renewal Notice", shall be issued by the Department of Revenue to notify motor vehicle owners of their ad valorem property tax liabilities and registration renewal deadline.

~~(79)~~~~(77)~~ Revenue Form 62A007S, "Motor Vehicle/Boat Property Tax Notice - Second Notice", shall be issued by the Department of Revenue to notify motor vehicle and boat owners of their delinquent ad valorem property tax liabilities.

~~(80)~~~~(78)~~ Revenue Form 62A008, "Motor Vehicle Tax Notice", shall be issued by the Department of Revenue to notify motor vehicle owners of their ad valorem property tax liabilities.

~~(81)~~~~(79)~~ Revenue Form 62A009, "Map Sales Invoice", shall be provided to the customer by the Department of Revenue as a receipt for payment of maps purchased.

~~(82)~~~~(80)~~ Revenue Form 62A010, "Notice for Boat Transfer", shall be issued to January 1 owners of boats transferred during the calendar year informing them of the ad valorem tax due on the transferred boat.

~~(83)~~~~(81)~~ Revenue Form 62A013, "Application for Assessment Moratorium Certificate", shall be filed by property owners seeking an assessment moratorium on qualifying existing property undergoing repair, rehabilitation or restoration. The form shall be filed with the proper administering agency of the county in which the property is located, thirty (30) days prior to restoration or repair.

~~(84)~~~~(82)~~ Revenue Form 62A015, "2014[2013] Motor Vehicle and Watercraft Property Tax Rate Certification", shall be submitted annually to the Department of Revenue by motor vehicle and watercraft taxing jurisdictions to certify the rates established by the taxing jurisdiction for motor vehicles and watercraft.

~~(85)~~~~(83)~~ Revenue Form 62A016, "Quietus", shall be issued by the Department of Revenue to certify that a county clerk is in good standing with regard to the conduct of ad valorem property tax collection duties.

~~(86)~~~~(84)~~ Revenue Form 62A017, "County Clerk's Claim for Calculation of Motor Vehicle and Boat Bills", shall be completed by the Department of Revenue and county clerk to certify the total number of motor vehicle and boat accounts for a given county and

determine the county clerk's compensation for making tax bills.

~~(87)~~~~(85)~~ Revenue Form 62A020, "Intercounty Property Tax Collections", shall be completed by the Department of Revenue to list distributions of ad valorem property tax made to individual taxing jurisdictions.

~~(88)~~~~(86)~~ Revenue Form 62A023, "Application for Exemption from Property Taxation", shall be filed by organizations seeking a property tax exemption under Ky. Const. Sec. 170. This form shall be filed with the property valuation administrator of the county in which the property is located.

~~(89)~~~~(87)~~ Revenue Form 62A030, "Request for Reproduction of PVA Public Records and Contract for Commercial Users", shall be submitted to request copies of documents required to be retained by the PVA.

~~(90)~~~~(88)~~ Revenue Form 62A044, "Affidavit for Correction/Exoneration of Motor Vehicle/Boat/Trailer Property Tax", shall be completed by the owner of a vehicle, boat, or trailer at the property valuation administrator's office in order to correct owner or vehicle, boat, or trailer information in the ad valorem tax computer system. The PVA shall present the form to the county clerk when a tax refund is authorized.

~~(91)~~~~(89)~~ Revenue Form 62A200(P), "2014[2013] Unmined Coal Property Tax Information Return", shall be the packet of files and instructions relating to Revenue Form 62A200 for use by owners or lessees of unmined minerals, reporting filer information with the Department of Revenue.

~~(92)~~~~(90)~~ Revenue Form 62A200, "2014[2013] Unmined Coal Property Tax Information Return", shall be filed by owners or lessees of unmined minerals, reporting filer information with the Department of Revenue.

~~(93)~~~~(91)~~ Revenue Form 62A200, "Schedule A Fee Property Ownership", shall be filed by owners or lessees of unmined minerals with the Department of Revenue, reporting ownership information for each parcel or royalty information for each leased parcel.

~~(94)~~~~(92)~~ Revenue Form 62A200, "Schedule B Leased Property", shall be filed by all lessees and sublessees with the Department of Revenue, reporting ownership information for each parcel or royalty information for each leased parcel.

~~(95)~~~~(93)~~ Revenue Form 62A200, "Schedule C Property or Stock Transfers", shall be filed by both purchasers and sellers of unmined mineral property, with the Department of Revenue, reporting details of the transaction.

~~(96)~~~~(94)~~ Revenue Form 62A200, "Schedule D Lease Terminations, Transfers or Assignments", shall be filed by lessors or lessees of unmined minerals, with the Department of Revenue, reporting the parcel number, the date the lease was terminated and the seams assigned.

~~(97)~~~~(95)~~ Revenue Form 62A200, "Schedule E Farm Exception to Unmined Minerals Tax", shall be filed by surface owners, who own the mineral rights in their entirety and are engaged primarily in farming, to be excepted from the unmined minerals tax.

~~(98)~~~~(96)~~ Revenue Form 62A200, "Schedule F Geological Information by County", shall be filed by owners or lessees of unmined minerals, with the Department of Revenue, reporting exploration and analytical information.

~~(99)~~~~(97)~~ Revenue Form 62A301-S, "Omitted Real Estate Property Tax Bill" shall be used by the sheriff to inform taxpayers of an omitted real estate property tax liability.

~~(100)~~~~(98)~~ Revenue Form 62A302, "Request for Information for Local Board of Tax Appeals", shall be filed by taxpayers with the property valuation administrator, if appealing their assessment on real property.

~~(101)~~~~(99)~~ Revenue Form 62A304, "Property Valuation Administrator's Recapitulation of Real Property Tax Roll", shall be filed by the property valuation administrator by the first Monday in April, showing a recapitulation of property assessments by type of property and by taxing district. This form shall also be known as "first recap".

~~(102)~~~~(100)~~ Revenue Form 62A305, "Property Valuation Administrator's Summary of Real Property Tax Roll Changes (Since Recapitulation)", shall be filed by the property valuation

administrator within six (6) days of the conclusion of the real property tax roll inspection period, showing all changes made since the submission of Revenue Form 62A304. This form shall also be known as "final recap" or "second recap".

~~(103)~~~~(101)~~ Revenue Form 62A307, "Property Owner Conference Record", shall be used by the property valuation administrator to document a property owner's appeal conference. The property owner or his or her representative shall be asked to sign the record and shall be given a copy of the record.

~~(104)~~~~(102)~~ Revenue Form 62A323, "Record of Additions and Deletions", shall be used by the PVA to report all real property additions and deletions for a particular assessment year.

~~(105)~~~~(103)~~ Revenue Form 62A329, "Annual Report of Domestic Life Insurance Companies", shall be filed by life insurance companies doing business in Kentucky, with the Department of Revenue, reporting the fair cash value of the company's intangible property, both taxable and exempt, and the aggregate amount.

~~(106)~~~~(104)~~ Revenue Form 62A350, "Application for Exemption Under the Homestead/Disability Amendment", shall be filed by property owners seeking an exemption from property taxes under Ky. Const. Sec. 170. This application shall be filed with the property valuation administrator of the county in which the residential unit is located.

~~(107)~~~~(105)~~ Revenue Form 62A352, "Notice to Real Property Owner of Assessment by Property Valuation Administrator", shall be mailed to the property owner by the property valuation administrator notifying him or her of the assessment amount and of his or her appeal rights.

~~(108)~~~~(106)~~ Revenue Form 62A353, "Notice of Listing of Omitted Real Property", shall be mailed by the property valuation administrator to the property owner. This document shall notify the property owner that his or her omitted property has been listed and assessed and of his or her appeal rights.

~~(109)~~~~(107)~~ Revenue Form 62A354, "Notice to Property Owner of Final Decision of Board of Assessment Appeals", shall be sent from the Board of Assessment Appeals to the property owner to inform him or her of its ruling.

~~(110)~~~~(108)~~ Revenue Form 62A358, "Receipt for Transferring Delinquent Property Tax Bills From the Sheriff to the County Clerk", shall be signed by both the sheriff and county clerk to affirm the number and total amount of delinquent tax bills transferred from the sheriff to the county clerk.

~~(111)~~~~(109)~~ Revenue Form 62A358-S, "Supplemental Receipt to Document Timely Postmarked Payments Received After the Delinquent Tax Bill Transfer Date", shall be signed by both the sheriff and the county clerk to affirm payments received by the sheriff via mail and postmarked timely after the transfer date.

~~(112)~~~~(110)~~ Revenue Form 62A359, "Sheriff's Report of Real Property Tax Bills Transferred to the County Clerk", shall be used by the sheriffs to report delinquent real estate tax bills that were transferred from the sheriff to the county clerk's office.

~~(113)~~~~(111)~~ Revenue Form 62A360, "Order Correcting Erroneous Assessment", shall be issued to the collection agency (county sheriff or clerk) and taxpayer correcting an erroneous mineral property tax assessment.

~~(114)~~~~(112)~~ Revenue Form 62A362, "Sheriff's Report of Delinquent Personal Property Tax Bills Transferred to the County Clerk", shall be used by the sheriff to report delinquent personal property tax bills transferred from the sheriff to the county clerk's office.

~~(115)~~~~(113)~~ Revenue Form 62A363, "County Clerk's Claim for Preparing Tax Bills", shall be submitted by the county clerk in order to receive payment for each property tax bill prepared, with one-half (1/2) paid out of the county treasury and one-half (1/2) paid out of the State Treasury.

~~(116)~~~~(114)~~ Revenue Form 62A363-B, "County Clerk's Claim for Preparing Omitted Tax Bills", shall be submitted by the county clerk in order to receive payment of one (1) dollar for each omitted property tax bill prepared, with one-half (1/2) paid out of the county treasury and one-half (1/2) paid out of the State Treasury.

~~(117)~~~~(115)~~ Revenue Form 62A364, "County Clerk's Monthly Report of Omitted Assessments", shall be used by the county clerk

to report omitted assessments made by the property valuation administrator.

~~(118)~~~~(116)~~ Revenue Form 62A365, "Nonresidency Affidavit", shall be filed as proof of nonresidency in Kentucky as of January 1, for ad valorem tax purposes.

~~(119)~~~~(117)~~ Revenue Form 62A366, "Order Correcting Erroneous Assessment", shall be filed by the property valuation administrator with the sheriff, to correct an error made in an assessment of property.

~~(120)~~~~(118)~~ Revenue Form 62A366-D, "Order Correcting Erroneous Delinquent Assessment", shall be filed by the property valuation administrator with the sheriff, to correct an error made in a delinquent assessment of property.

~~(121)~~~~(119)~~ Revenue Form 62A366R, "Exoneration Form for Property Tax Refund", shall be filed by a taxpayer for refunds of property tax.

~~(122)~~~~(120)~~ Revenue Form 62A367, "Authorization for Preparing Additional/Supplemental Property Tax Bills", shall be used by a property valuation administrator to prepare additional or supplemental tax bills.

~~(123)~~~~(121)~~ Revenue Form 62A367-A, "Instructions for Preparation of Additional/Supplemental Tax Bills and Official Receipt", shall be provided to assist the PVA with the preparation of additional or supplemental tax bills.

~~(124)~~~~(122)~~ Revenue Form 62A368-A, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue delinquent property tax collections for the 1997 tax year only.

~~(125)~~~~(123)~~ Revenue Form 62A368-B, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue delinquent property tax collections for tax years after 1997.

~~(126)~~~~(124)~~ Revenue Form 62A369, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue delinquent property tax collections for 1996 and earlier tax years.

~~(127)~~~~(125)~~ Revenue Form 62A369-A, "County Clerk's Monthly Report of Delinquent Tax Collections", shall be used by county clerks to report monthly to the Department of Revenue state commission from delinquent property tax collections.

~~(128)~~~~(126)~~ Revenue Form 62A370, "Kentucky Department of Revenue Certificate of Registration", shall be issued by the Department of Revenue to individuals, corporations or partnerships proving eligibility to purchase certificates of delinquency. This certificate shall be presented to the county clerk at the time certificates of delinquency are offered for sale.

~~(129)~~~~(127)~~ Revenue Form 62A370A, "Kentucky Department of Revenue Application for Certificate of Registration to Purchase Certificates of Delinquency", shall be submitted to the Department of Revenue by individuals, corporations or partnerships seeking to purchase certificates of delinquency offered for sale by the county clerk.

~~(130)~~~~(128)~~ Revenue Form 62A371, "Attestation Form For Use When Taxpayer Cannot Make Contact With A Third Party Purchaser", shall be used by the taxpayer to attest to the county clerk that the taxpayer attempted to contact the third party purchaser in the manner specified by KRS 134.127(3)(e) and was ~~unsuccessful~~~~[successful]~~.

~~(131)~~~~(129)~~ Revenue Form 62A372, "Sheriff's List of Orders Correcting Erroneous Assessments", shall be used by the sheriff to report all exoneration made to the tax bills by the property valuation administrator.

~~(132)~~~~(130)~~ Revenue Form 62A372-A, "Certification", shall be used by the sheriff to affirm that the list of exoneration is accurate.

~~(133)~~~~(131)~~ Revenue Form 62A373, "Certificate of Transfer for Property Tax Payment", shall be issued by the sheriff to a person who has paid property taxes on behalf of another and wishes to be treated as a transferee under KRS 134.121.

~~(134)~~~~(132)~~ Revenue Form 62A374, "County Clerk Certificate of Delinquency Sale Registration", shall be used by the county clerk to register third parties interested in purchasing certificates of delinquency offered for sale by the county clerk.

~~(135)~~~~(133)~~ Revenue Form 62A375, "Release of Certificate of

Delinquency Assigned to a Third Party", shall be used by the county clerk to release the lien of a certificate of delinquency that has been refunded to a third party purchaser.

(136) [(134)] Revenue Form 62A377, "In House Release of Third Party Purchaser Lien When Lien is Paid to Clerk", shall be used by the county clerk to release a certificate of delinquency when the certificate of delinquency has been paid by the taxpayer and the third party purchaser cannot be located.

(137) [(135)] Revenue Form 62A378, "Report of Mobile Homes and Recreational Vehicles Not Registered in this State", shall be filed by every person providing rental space for mobile homes and recreational vehicles not registered in Kentucky. This form shall be filed with the property valuation administrator of the county in which the park is located.

(138) [(136)] Revenue Form 62A379, "Listing of Omitted Real Property", shall be used by a taxpayer to voluntarily list any property previously omitted from the tax roll or shall be used by a property valuation administrator to list any involuntarily omitted property.

(139) [(137)] Revenue Form 62A380, "Notification of Updated Mailing Address from Sheriff to Property Valuation Administrator", shall be used by the sheriff to provide an updated address to the property valuation administrator in accordance with KRS 134.119(8).

(140) [(138)] Revenue Form 62A384C, "Clay Property Tax Return", shall be filed with the Department of Revenue by persons owning or leasing clay property, reporting the owner's name and address, percent ownership, product tons, and royalty rate.

(141) [(139)] Revenue Form 62A384C(l) "Instructions to Complete Clay Property Tax Return for 2013 Tax Year", shall be used by owners and lessees of land containing mineable clay minerals to file Revenue Form 62A384C.

(142) [(140)] Revenue Form 62A384-G, "Natural Gas Property Tax Return", shall be filed with the Department of Revenue by persons owning or leasing developed natural gas properties, reporting the location of the property, total yearly gas production, number of producing wells, and the total dollar value of production.

(143) [(141)] Revenue Form 62A384-G/O(l) "Gas/Oil", shall be used as a letter informing owners of natural gas and oil property of the responsibility to file, the filing deadline, and where to locate the forms.

(144) [(142)] Revenue Form 62A384L, "Limestone, Sand and Gravel Property Tax Return", shall be filed with the Department of Revenue by persons owning or leasing limestone, sand or gravel properties reporting mineral location, type of mining and production in the last three (3) years.

(145) [(143)] Revenue Form 62A384-O, "Oil Property Tax Return Lease Report", shall be filed with the Department of Revenue by all persons, corporations, businesses and partnerships owning, leasing or having knowledge of developed oil properties to report developed oil property in Kentucky.

(146) [(144)] Revenue Form 62A385, "Sheriff's Official Receipt for Property Tax Bills", shall be used by sheriffs to acknowledge receipt of the county's property tax bills and to document the total tax amount to be collected for each taxing district.

(147) [(145)] Revenue Form 62A385-A, "Sheriff's Receipt For Unpaid and Partially Paid Tax Bills", shall be used by incoming sheriffs to give receipt to the outgoing sheriff for the unpaid and partially paid tax bills outstanding when he or she assumes office.

(148) [(146)] Revenue Form 62A393, "Sheriff's Property Tax Account Statement", shall be used by the Department of Revenue to conduct the annual property tax settlement with the sheriff.

(149) [(147)] Revenue Form 62A393-A, "Incoming Sheriff's Property Tax Account Statement", shall be used by the Department of Revenue to conduct the property tax settlement with the incoming sheriff.

(150) [(148)] Revenue Form 62A393-B, "Outgoing Sheriff's Property Tax Account Statement", shall be used by the Department of Revenue to conduct the property tax settlement with the outgoing sheriff.

(151) [(149)] Revenue Form 62A394, "Sheriff's Monthly Report of Property Tax Collections", shall be used by sheriffs to report to the Department of Revenue property tax collections for the month.

(152) [(150)] Revenue Form 62A394-MV, "County Clerk's Monthly Report of Motor Vehicle Property Tax Collections", shall be submitted by the county clerk to the Department of Revenue and local taxing jurisdictions to report ad valorem property tax collections for the month.

(153) [(151)] Revenue Form 62A398, "Property Valuation Administrator's Bond", shall be completed by property valuation administrators evidencing surety with the Commonwealth and a local school board and affirming a commitment to fulfill the duties of the office.

(154) [(152)] Revenue Form 62A500(P), "2014[2013] Personal Property Tax Forms and Instructions", shall be the packet of files and instructions relating to Revenue Form 62A500 for use by owners or lessees of tangible personal property reporting taxpayer information, original cost of tangible property and reported value of tangible property with either the property valuation administrator of the county of taxable situs or with the Department of Revenue.

(155) [(153)] Revenue Form 62A500, "2014[2013] Tangible Personal Property Tax Return", shall be filed by owners or lessees of tangible personal property reporting taxpayer information, original cost of tangible property and reported value of tangible property with either the property valuation administrator of the county of taxable situs or with the Department of Revenue.

(156) [(154)] Revenue Form 62A500-A, "2014[2013] Tangible Personal Property Tax Return (Aircraft Assessments Only)", shall be filed by owners or lessees of aircraft not used for commercial purposes, with either the property valuation administrator of the county of taxable situs or with the Department of Revenue, reporting the federal registration number, make and model, and taxpayer's value for each aircraft.

(157) [(155)] Revenue Form 62A500-C, "Consignee Tangible Personal Property Tax Return", shall be filed by persons in possession of consigned inventory, that has not been reported on Revenue Form 62A500, with either the property valuation administrator of the county of taxable situs or the Department of Revenue, reporting consignor information and consigned inventory information.

(158) [(156)] Revenue Form 62A500-L, "Lessee Tangible Personal Property Tax Return", shall be filed by lessees of tangible personal property who did not list the property on Revenue Form 62A500, with either the property valuation administrator of the county of taxable situs or with the Department of Revenue, reporting lessor information and equipment information.

(159) [(157)] Revenue Form 62A500-M1, "Boat Dealer's Used Inventory Listing for Line 31 Tangible Personal Property Tax Return", shall be filed by boat dealers with the property valuation administrator of each county of taxable situs or with the Department of Revenue, containing a detailed listing of used boats held for sale by a licensed boat dealer.

(160) [(158)] Revenue Form 62A500-S1, "Automobile Dealer's Inventory Listing for Line 34 Tangible Personal Property Tax Return", shall be filed by automobile dealers, dealers with new boat and marine equipment held under a floor plan or dealers with new farm machinery held under a floor plan with the property valuation administrator of each county of taxable situs or with the Department of Revenue, containing a detailed listing of property reported on line 34 of the Tangible Personal Property Tax Return.

(161) [(159)] Revenue Form 62A500-W, "2014[2013] Tangible Personal Property Tax Return (Documented Watercraft)", shall be filed by owners or lessees of documented vessels not used for commercial purposes, with either the property valuation administrator of the county of taxable situs or with the Department of Revenue, reporting the coast guard number, make and model and taxpayer's value for each watercraft.

(162) [(160)] Revenue Form 62A600, "Domestic Savings and Loan Tax Return", shall be filed with the Department of Revenue by savings and loans operating solely in Kentucky, reporting the balances in their capital accounts.

(163) [(161)] Revenue Form 62A601, "Foreign Savings and Loan Tax Return", shall be filed with the Department of Revenue by foreign savings and loans authorized to do business in this state, reporting the balances in their capital accounts.

(164) [(162)] Revenue Form 62A601-S2, "Schedule B,

Computation of Exempt Securities", shall be filed with the Department of Revenue, by taxpayers filing Revenue Form 62A600 or 62A601, reporting the market value of U. S. government securities.

~~(165)~~~~(163)~~ Revenue Form 62A850, "Bank Deposits Tax Return", shall be filed with the Department of Revenue by financial institutions, reporting the amount of its deposits as of the preceding January 1.

~~(166)~~~~(164)~~ Revenue Form 62A862, "Certification of Tax Rate for Bank Deposits Franchise Tax", shall be filed by the local taxing district with the Department of Revenue to notify the Department of Revenue of the rate set on bank deposits.

~~(167)~~~~(165)~~ Revenue Form 62A863, "Financial Institutions Local Deposits Summary Report", shall be filed with the Department of Revenue, by financial institutions, reporting all deposits located within the state as of the preceding June 30, along with a copy of the most recent summary of deposits filed with the Federal Deposit Insurance Corporation.

~~(168)~~~~(166)~~ Revenue Form 62A863-A, "Schedule A, Summary of Net Deposits", shall be filed with the Department of Revenue, by financial institutions filing Revenue Form 62A863, to summarize deposits.

~~(169)~~~~(167)~~ Revenue Form 62A880, "Personal Property Assessment", shall be sent by the Department of Revenue to the owner of omitted personal property notifying him or her of the value assessed by the department as well as all applicable penalties and interest.

~~(170)~~~~(168)~~ Revenue Form 62B003, "Unmined Coal Notice of Tax Assessment", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in unmined coal property.

~~(171)~~~~(169)~~ Revenue Form 62B011, "Limestone, Sand, or Gravel Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in limestone, sand or gravel property.

~~(172)~~~~(170)~~ Revenue Form 62B012, "Oil Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in oil property.

~~(173)~~~~(171)~~ Revenue Form 62B013, "Clay Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in clay property.

~~(174)~~~~(172)~~ Revenue Form 62B015, "Gas Assessment Notice", shall be sent by the Department of Revenue to the taxpayer notifying him or her of the value of his or her interest in gas property.

~~(175)~~~~(173)~~ Revenue Form 62F003, "Appeals Process for Real Property Assessments", shall be an informational brochure on the procedure to follow to appeal an assessment on real property.

~~(176)~~~~(174)~~ Revenue Form 62F015, "PVA Open Records Commercial Fee Guidelines", shall be used by the PVA to establish fees to be charged for the cost of reproduction, creation, or other acquisition of records.

~~(177)~~~~(175)~~ Revenue Form 62F031, "Appeal to Local Board of Assessment Appeals", shall be filed with the county clerk by any taxpayer who wishes to appeal his or her assessment on real property.

~~(178)~~~~(176)~~ Revenue Form 62F200, "Important Reminder" shall be a postcard mailed to previous filers of the Unmined Coal Property Tax Information Return as a reminder of the responsibility to file, the filing deadline, and where to locate the forms.

~~(179)~~~~(177)~~ Revenue Form 62F384-G, "Important Reminder" shall be a postcard mailed to previous filers of the Natural Gas Property Tax Return as a reminder of the responsibility to file, the filing deadline, and where to locate the forms.

~~(180)~~~~(178)~~ Revenue Form 62F500, "Important Reminder" shall be a postcard mailed to previous filers of the Tangible Personal Property Tax Return as a reminder of the responsibility to file, the filing deadline and where to locate the forms.

~~(181)~~~~(179)~~ Revenue Form 62F1341, "Exemptions Allowed for Savings and Loans, Savings Banks and Similar Institutions for Intangible Property Tax Purposes", shall inform taxpayers, subject to intangible property tax on the value of their capital stock, of

those institutions which issue obligations that are exempt from state ad valorem taxation.

Section 2. Severance Taxes - Required Forms. (1) Revenue Form 10A100, "Kentucky Tax Registration Application", shall be filed by taxpayers with a coal severance and processing tax account listing taxpayer information including mine name and mining permit number.

(2) Revenue Form 10A104, "Update Or Cancellation Of Kentucky Tax Account(s)", shall be used by taxpayers with a coal severance and processing tax account to update business information or to cancel the account.

(3) Revenue Form 55A004, "Coal Severance Tax Seller/Purchaser Certificate", shall be filed by the taxpayer to verify purchase coal deductions.

(4) Revenue Form 55A100, "Coal Severance Tax Return", shall be filed monthly by the taxpayer to report production and tax due.

(5) Revenue Form 55A100, "Part IV - Schedule of Purchased Coal", shall be used by the taxpayer to report coal purchased for processing and resale. "Part V - Schedule for Thin Seam Coal Tax Credit", shall be used by the taxpayer to apply for tax credit for underground mining of thin coal seams.

(6) Revenue Form 55A101, "Coal Severance Tax Return Instructions", shall be included with the coal tax return mailed to the taxpayer to assist in the completion of his or her return.

(7) Revenue Form 55A131, "Credit Memorandum", shall be used by the department to issue a credit to the taxpayer for an overpayment rather than a refund.

(8) Revenue Form 55A209, "Severance Tax Refund Application", shall be used by the taxpayer for the purpose of requesting a refund of tax overpaid.

(9) Revenue Form 56A001, "Application for Certificate of Registration Minerals and Natural Gas Tax", shall be used by persons dealing in minerals, natural gas or natural gas liquids who wish to register with the Department of Revenue to acquire an account number.

(10) Revenue Form 56A100, "Natural Gas and Natural Gas Liquids Tax Return", shall be used by registered natural gas and natural gas liquids taxpayers monthly to report production and tax due.

(11) Revenue Form 56A101, "Minerals Tax Return", shall be used by registered mineral taxpayers monthly to report production and tax due.

(12) Revenue Form 56A106, "Minerals Tax Certificate of Exemption", shall be used by mineral taxpayers to claim exemptions from minerals tax for minerals purchased for the maintenance of a privately maintained but publicly dedicated road.

(13) Revenue Form 56A107, "Schedule A, Allocation of Gross Value of Minerals Severed in Kentucky and Schedule B, Minerals Purchased from Others for Processing by Taxpayer", shall be used by mineral taxpayers to compute gross value of minerals to be allocated and to show the allocation by county of the gross value of minerals severed in Kentucky and also shall be used by a taxpayer for showing minerals that are purchased from others for processing by the taxpayer.

(14) Revenue Form 56A108, "Schedule A, Gross Value of Natural Gas Sold to Nonconsumers and Schedule B, Taxable Gross Value of Natural Gas and Natural Gas Liquids Extracted in Kentucky by Taxpayer - Allocation", shall be used by natural gas taxpayers to show details of all natural gas extracted in Kentucky and sold to nonconsumers and also shall be used by natural gas taxpayers to allocate the natural gas to the county or counties where the natural gas or natural gas liquids were located prior to extraction.

(15) Revenue Form 56A109, "Schedule C, Natural Gas First Purchased by Taxpayer From Kentucky Producers", shall be used by natural gas taxpayers who are first purchasers of natural gas to show gross value by county or counties from which the natural gas was extracted.

(16) Revenue Form 56A110, "Minerals Tax Return Attachment, Schedule C, Computation of Clay Severed and Processed in Kentucky and Allocation of Tax Attributable to Clay", shall be used

by mineral taxpayers that sever clay to compute tax due.

(17) Revenue Form 56A112, "Crude Petroleum Transporter's Monthly Report, Kentucky Oil Production Tax", shall be used by registered crude petroleum transporter's for reporting gross value and tax due.

(18) Revenue Form 56A113, "Minerals Tax Credit for Limestone Sold in Interstate Commerce", shall be used by mineral taxpayers for the purpose of determining the eligibility for the minerals tax credit.

(19) Revenue Form 56A114, "Crude Petroleum Transporter's Application for Registration", shall be used by crude petroleum transporters who wish to acquire an account number with the Kentucky Department of Revenue.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Property tax - referenced material:

1. Revenue Form 61A200(P), "Property Tax Forms and Instructions for Public Service Companies 2014[2013]", October 2013[2012];

2. Revenue Form 61A200, "Public Service Company Property Tax Return for Year Ending December 31, 2013[2012]", October 2013[2012];

3. Revenue Form 61A200(A), "Report of Total Unit System and Kentucky Operations", October 2013[2012];

4. Revenue Form 61A200(B), "Report of Kentucky Vehicles, Car Lines and Watercraft", October 2013[2012];

5. Revenue Form 61A200(C), "Report of Total Unit Operations Balance Sheet", October 2013[2012];

6. Revenue Form 61A200(D), "Report of Total Unit Operations Income Statement", October 2013[2012];

7. Revenue Form 61A200(E), "Filing Extension Application", October 2013[2012];

8. Revenue Form 61A200(G), "Report of Capital Stocks", October 2013[2012];

9. Revenue Form 61A200(H), "Report of Funded Debt", October 2013[2012];

10. Revenue Form 61A200(I), "Business Summary by Taxing Jurisdiction", October 2013[2012];

11. Revenue Form 61A200(J), "Property Summary by Taxing Jurisdiction, Operating and Nonoperating Property", August 2013[2012];

12. Revenue Form 61A200(K), "Operating Property Listing by Taxing Jurisdiction", October 2013[2012];

13. Revenue Form 61A200(K2), "Nonoperating/Nonutility Property Listing by Taxing Jurisdiction", October 2013[2012];

14. Revenue Form 61A200(L), "Report of Allocation Factors, Operating and Noncarrier Property for All Interstate Companies", October 2013[2012];

15. Revenue Form 61A200(M), "Report of Property and Business Factors for Interstate Railroad and Sleeping Car Companies", October 2013[2012];

16. Revenue Form 61A200(N1), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", October 2013[2012];

17. Revenue Form 61A200(N2), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", October 2013[2012];

18. Revenue Form 61A200(N3), "Summary Report of System and Kentucky Operating Lease Payments", October 2013[2012];

19. Revenue Form 61A200(O), "Railroad Private Car Mileage Report", October 2013[2012];

20. Revenue Form 61A200(Q), "Supplemental Report of Operations for Contained and Residential Landfills", October 2013[2012];

21. Revenue Form 61A200(R), "Report of Property Subject to the Pollution Control Tax Exemption", October 2013[2012];

22. Revenue Form 61A200(U), "Industrial Revenue Bond Property", October 2013[2012];

23. Revenue Form 61A202, "2014[2013] Public Service Company Property Tax Return for Railroad Car Line", October 2013[2012];

24. Revenue Form 61A206(P), "Public Service Company

Property Tax Forms and Instructions for Commercial Air Passenger and Air Freight Carriers 2014[2013]", October 2013[2012];

25. Revenue Form 61A206, "Public Service Company Property Tax Return For Commercial Air Passenger and Air Freight Carriers", October 2013[2012];

26. Revenue Form 61A206(A), "Filing Extension Application for Public Service Company Property Tax Return", October 2013[2012];

27. Revenue Form 61A206(B), "Report of Kentucky Registered and Licensed Motor Vehicles", October 2013[2012];

28. Revenue Form 61A206(C), "Report of Financial Operations for Commercial Air Passenger and Air Freight Carriers", October 2013[2012];

29. Revenue Form 61A206(D-1), "Report of System Aircraft Fleet", October 2013[2012];

30. Revenue Form 61A206(D-2), "Report of System Aircraft Fleet", October 2013[2012];

31. Revenue Form 61A206(D-3), "Report of System Aircraft Fleet", October 2013[2012];

32. Revenue Form 61A206(E), "Report of Kentucky Flight Statistics By Airport", October 2013[2012];

33. Revenue Form 61A206(F), "Report of System and Kentucky Allocation Factors", October 2013[2012];

34. Revenue Form 61A206(G), "Report of Funded Debt", October 2013[2012];

35. Revenue Form 61A206(H), "Report of Operating Leased Real Property Located in Kentucky By Taxing District", October 2013[2012];

36. Revenue Form 61A206(I), "Report of Operating Leased Personal Property Located in Kentucky By Taxing District", October 2013[2012];

37. Revenue Form 61A206(J), "Summary Report of System and Kentucky Operating Lease Payments", October 2013[2012];

38. Revenue Form 61A206(K), "Report of Owned Real Property Located in Kentucky By Taxing District", October 2013[2012];

39. Revenue Form 61A206(L), "Report of Owned Personal Property Located In Kentucky By Taxing District", October 2013[2012];

40. Revenue Form 61A206(M), "Summary Report of Total System and Kentucky Operations", October 2013[2012];

41. Revenue Form 61A206(N), "Industrial Revenue Bond Property", October 2013[2012];

42. Revenue Form 61A206(O), "Public Service Company Sales", October 2013[2012];

43. Revenue Form 61A207(P), "Commercial Watercraft Personal Property Tax Return 2014[2013]", October 2013[2012];

44. Revenue Form 61A207, "2014[2013] Commercial Watercraft Personal Property Tax Return", October 2013[2012];

45. Revenue Form 61A207(A), "Report of Owned Vessels in Your Possession", October 2013[2012];

46. Revenue Form 61A207(B), "Report of Owned Vessels - in Possession of Others", October 2013[2012];

47. Revenue Form 61A207(C), "Report of Nonowned Vessels in Your Possession", October 2013[2012];

48. Revenue Form 61A207(D), "Commercial Watercraft Valuation Worksheet", October 2013[2012];

49. Revenue Form 61A207(E), "Report of Kentucky Route Miles", October 2013[2012];

50. Revenue Form 61A207(F), "Report of System Route Miles", October 2013[2012];

51. Revenue Form 61A209, "Public Service Company Sales", October 2013[2012];

52. Revenue Form 61A211, "Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs", October 2013[2012];

53. Revenue Form 61A211(I), "Instructions Public Service Company Schedule of Owned and/or Leased Motor Vehicles with Kentucky Situs", October 2013[2012];

54. Revenue Form 61A211(IP), "Instructions For Editing the Public Service Company Motor Vehicle Printout", March 2013;

55. Revenue Form 61A230, "Notice of Assessment", February

- 2010;
- 56.[55-] Revenue Form 61A240, "Notice of Assessment", July 2011;
- 57.[56-] Revenue Form 61A250, "Notice of Assessment", August 2008;
- 58.[57-] Revenue Form 61A255, "Public Service Company Property Tax Statement", January 2012;
- 59.[58-] Revenue Form 61A255(I), "Instructions for 61A255, Public Service Company Property Tax Statement", July 2008;
- 60.[59-] Revenue Form 61A500(P), "2014[2013] Personal Property Tax Forms and Instructions for Communications Service Providers and Multichannel Video Programming Service Providers", October 2013[2012];
- 61.[60-] Revenue Form 61A500, "2014[2013] Tangible Personal Property Tax Return for Communications Service Providers and Multichannel Video Programming Service Providers", October 2013[2012];
- 62.[61-] Revenue Form 61A500(H), "Report of Total Personal Tangible Property in Kentucky", October 2013[2012];
- 63.[62-] Revenue Form 61A500(I), "Summary of Gross Personal Tangible Property Listing by Taxing District", October 2013[2012];
- 64.[63-] Revenue Form 61A500(J), "Summary of Reported Personal Tangible Property Listing by Taxing District", October 2013[2012];
- 65.[64-] Revenue Form 61A500(K), "Personal Tangible Property Listing by Taxing District", October 2013[2012];
- 66.[65-] Revenue Form 61A508, "Annual Report of Distilled Spirits in Bonded Warehouse", October 2013[2012];
- 67.[66-] Revenue Form 61A508-S1, "Schedule 1 Department of Property Valuation Cost of Production Schedule", October 2013[2012];
- 68.[67-] Revenue Form 61A508-S2, "Schedule 2 Department of Property Valuation Storage Cost Schedule", October 2013[2012];
- 69.[68-] Revenue Form 61A508-S3, "Schedule 3 Schedule of Bulk Sales", October 2013[2012];
- 70.[69-] Revenue Form 61A508-S4, "Schedule 4", October 2013[2012];
- 71.[70-] Revenue Form 61A508-S5, "Schedule 5", October 2013[2012];
72. Revenue Form 61A508-S6, "Schedule 6 Industrial Revenue Bond Property", October 2013;
- 73.[71-] Revenue Form 61A509, "Distilled Spirits or Telecoms Property Tax Statement", January 2012;
- 74.[72-] Revenue Form 61F007, "Notification Protesting Your Commercial Watercraft Assessment", July 2011;
- 75.[73-] Revenue Form 61F008, "Notification Protesting Your Assessment", July 2011;
- 76.[74-] Revenue Form 61F009, "Notification Protesting Your Assessment", July 2011;
- 77.[75-] Revenue Form 61F010, "Property Value Assessments for Public Service and Centrally Assessed Companies - Assessment of Distilled Spirits in Bonded Warehouses", March 2010;
- 78.[76-] Revenue Form 62A007, "Motor Vehicle Tax and/or Registration Renewal Notice", 2006;
- 79.[77-] Revenue Form 62A007S, "Motor Vehicle/Boat Property Tax Notice - Second Notice", 2006;
- 80.[78-] Revenue Form 62A008, "Motor Vehicle Tax Notice", 2006;
- 81.[79-] Revenue Form 62A009, "Map Sales Invoice", July, 2006;
- 82.[80-] Revenue Form 62A010, "Notice for Boat Transfer", 2009;
- 83.[81-] Revenue Form 62A013, "Application for Assessment Moratorium Certificate", December 2009;
- 84.[82-] Revenue Form 62A015, "2014[2013] Motor Vehicle and Watercraft Property Tax Rate Certification", 2013[2012];
- 85.[83-] Revenue Form 62A016, "Quietus", 2012;
- 86.[84-] Revenue Form 62A017, "County Clerk's Claim for Calculation of Motor Vehicle and Boat Bills", 2009;
- 87.[85-] Revenue Form 62A020, "Intercounty Property Tax Collections", 2009;
- 88.[86-] Revenue Form 62A023, "Application for Exemption from Property Taxation", July 2013[December 2011];
- 89.[87-] Revenue Form 62A030, "Request for Reproduction of PVA Public Records and Contract for Commercial Users", February 2008;
- 90.[88-] Revenue Form 62A044, "Affidavit for Correction/Exoneration of Motor Vehicle/Boat/Trailer Property Tax", February 2009;
- 91.[89-] Revenue Form 62A200(P), "2014[2013] Unmined Coal Property Tax Information Return", December 2013[2012];
- 92.[90-] Revenue Form 62A200, "2014[2013] Unmined Coal Property Tax Information Return", December 2013[2012];
- 93.[91-] Revenue Form 62A200, "Schedule A Fee Property Ownership", December 2013[2012];
- 94.[92-] Revenue Form 62A200, "Schedule B Leased Property", December 2013[2012];
- 95.[93-] Revenue Form 62A200, "Schedule C Property or Stock Transfers", December 2013[2012];
- 96.[94-] Revenue Form 62A200, "Schedule D Lease Terminations, Transfers or Assignments", December 2013[2012];
- 97.[95-] Revenue Form 62A200, "Schedule E Farm Exception to Unmined Minerals Tax", December 2013[2012];
- 98.[96-] Revenue Form 62A200, "Schedule F Geological Information by County", December 2013[2012];
- 99.[97-] Revenue Form 62A301-S, "Omitted Real Estate Property Tax Bill", January 2013;
- 100.[98-] Revenue Form 62A302, "Request for Information for Local Board of Tax Appeals", September 2005;
- 101.[99-] Revenue Form 62A304, "Property Valuation Administrator's Recapitulation of Real Property Tax Roll", December 2008;
- 102.[100-] Revenue Form 62A305, "Property Valuation Administrator's Summary of Real Property Tax Roll Changes (Since Recapitulation)", December 2008;
- 103.[101-] Revenue Form 62A307, "Property Owner Conference Record", September 2005;
- 104.[102-] Revenue Form 62A323, "Record of Additions and Deletions", December 2008;
- 105.[103-] Revenue Form 62A329, "Annual Report of Domestic Life Insurance Companies", August 2010;
- 106.[104-] Revenue Form 62A350, "Application for Exemption Under the Homestead/Disability Amendment", December 2011;
- 107.[105-] Revenue Form 62A352, "Notice to Real Property Owner of Assessment by Property Valuation Administrator", April 2005;
- 108.[106-] Revenue Form 62A353, "Notice of Listing of Omitted Real Property", September 2005;
- 109.[107-] Revenue Form 62A354, "Notice to Property Owner of Final Decision of Board of Assessment Appeals", August 2006;
- 110.[108-] Revenue Form 62A358, "Receipt for Transferring Delinquent Property Tax Bills From the Sheriff to the County Clerk", December 2009;
- 111.[109-] Revenue Form 62A358-S, "Supplemental Receipt to Document Timely Postmarked Payments Received After the Delinquent Tax Bill Transfer Date", March 2010;
- 112.[110-] Revenue Form 62A359, "Sheriff's Report of Real Property Tax Bills Transferred to the County Clerk," December 2009;
- 113.[111-] Revenue Form 62A360, "Order Correcting Erroneous Assessment", 2011;
- 114.[112-] Revenue Form 62A362, "Sheriff's Report of Delinquent Personal Property Tax Bills Transferred to the County Clerk", December 2012;
- 115.[113-] Revenue Form 62A363, "County Clerk's Claim for Preparing Tax Bills", December 2007;
- 116.[114-] Revenue Form 62A363-B, "County Clerk's Claim for Preparing Omitted Tax Bills", December 2007;
- 117.[115-] Revenue Form 62A364, "County Clerk's Monthly Report of Omitted Assessments", February 2006;
- 118.[116-] Revenue Form 62A365, "Nonresidency Affidavit", January 2012;
- 119.[117-] Revenue Form 62A366, "Order Correcting

Erroneous Assessment", December 2013[2012];
120.[118.] Revenue Form 62A366-D, "Order Correcting Erroneous Delinquent Assessment", December 2013[2012];
121.[119.] Revenue Form 62A366R, "Exoneration Form for Property Tax Refund", December 2013[2012];
122.[120.] Revenue Form 62A367, "Authorization for Preparing Additional/Supplemental Property Tax Bills", December 2008;
123.[121.] Revenue Form 62A367-A, "Instructions for Preparation of Additional/Supplemental Tax Bills and Official Receipt", November 2011;
124.[122.] Revenue Form 62A368-A, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
125.[123.] Revenue Form 62A368-B, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
126.[124.] Revenue Form 62A369, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
127.[125.] Revenue Form 62A369-A, "County Clerk's Monthly Report of Delinquent Tax Collections", February 2006;
128.[126.] Revenue Form 62A370, "Kentucky Department of Revenue Certificate of Registration", November 2009;
129.[127.] Revenue Form 62A370A, "Kentucky Department of Revenue Application for Certificate of Registration to Purchase Certificates of Delinquency", October 2011;
130.[128.] Revenue Form 62A371, "Attestation Form For Use When Taxpayer Cannot Make Contact With A Third Party Purchaser", January 2013;
131.[129.] Revenue Form 62A372, "Sheriff's List of Orders Correcting Erroneous Assessments", February 2006;
132.[130.] Revenue Form 62A372-A, "Certification", February 2006;
133.[131.] Revenue Form 62A373, "Certificate of Transfer for Property Tax Payment", January 2010;
134.[132.] Revenue Form 62A374, "County Clerk Certificate of Delinquency Sale Registration", November 2010;
135.[133.] Revenue Form 62A375, "Release of Certificate of Delinquency Assigned to a Third Party", February 2011;
136.[134.] Revenue Form 62A377, "In House Release Of Third Party Purchaser Lien When Lien Is Paid To Clerk", January 2013;
137.[135.] Revenue Form 62A378, "Report of Mobile Homes and Recreational Vehicles Not Registered in this State", August 2013[2010];
138.[136.] Revenue Form 62A379, "Listing of Omitted Real Property", December 2013[November 2012];
139.[137.] Revenue Form 62A380, "Notification of Updated Mailing Address from Sheriff to Property Valuation Administrator", September 2010;
140.[138.] Revenue Form 62A384C, "Clay Property Tax Return", January 2013;
141.[139.] Revenue Form 62A384C(I), "Instructions to Complete Clay Property Tax Return[for 2013 Tax Year]", January 2014[2013];
142.[140.] Revenue Form 62A384-G, "Natural Gas Property Tax Return", January 2013;
143.[141.] Revenue Form 62A384-G/O(I), "Gas/Oil", January 2014[2013];
144.[142.] Revenue Form 62A384L, "Limestone, Sand and Gravel Property Tax Return", January 2014[2013];
145.[143.] Revenue Form 62A384-O, "Oil Property Tax Return Lease Report", January 2013;
146.[144.] Revenue Form 62A385, "Sheriff's Official Receipt for Property Tax Bills", February 2006;
147.[145.] Revenue Form 62A385-A, "Sheriff's Receipt for Unpaid and Partially Paid Tax Bills", February 2006;
148.[146.] Revenue Form 62A393, "Sheriff's Property Tax Account Statement", February 2006;
149.[147.] Revenue Form 62A393-A, "Incoming Sheriff's Property Tax Account Statement", February 2006;
150.[148.] Revenue Form 62A393-B, "Outgoing Sheriff's Property Tax Account Statement", February 2006;
151.[149.] Revenue Form 62A394, "Sheriff's Monthly Report of Property Tax Collections", January 2010;
152.[150.] Revenue Form 62A394-MV, "County Clerk's Monthly Report of Motor Vehicle Property Tax Collections", August

2011;
153.[151.] Revenue Form 62A398, "Property Valuation Administrator's Bond", September 2010;
154.[152.] Revenue Form 62A500(P), "2014[2013] Personal Property Tax Forms and Instructions", November 2013[2012];
155.[153.] Revenue Form 62A500, "2014[2013] Tangible Personal Property Tax Return", November 2013[2012];
156.[154.] Revenue Form 62A500-A, "2014[2013] Tangible Personal Property Tax Return (Aircraft Assessments Only)", November 2013[2012];
157.[155.] Revenue Form 62A500-C, "Consignee Tangible Personal Property Tax Return", November 2013[2012];
158.[156.] Revenue Form 62A500-L, "Lessee Tangible Personal Property Tax Return", November 2013[2012];
159.[157.] Revenue Form 62A500-M1, "Boat Dealer's Used Inventory Listing for Line 31 Tangible Personal Property Tax Return", November 2013[2012];
160.[158.] Revenue Form 62A500-S1, "Automobile Dealer's Inventory Listing for Line 34 Tangible Personal Property Tax Return", November 2013[2012];
161.[159.] Revenue Form 62A500-W, "2014[2013] Tangible Personal Property Tax Return (Documented Watercraft)", November 2013[2012];
162.[160.] Revenue Form 62A600, "Domestic Savings and Loan Tax Return", August 2013[2011];
163.[161.] Revenue Form 62A601, "Foreign Savings and Loan Tax Return", August 2013[2011];
164.[162.] Revenue Form 62A601-S2, "Schedule B, Computation of Exempt Securities", August 2013[2011];
165.[163.] Revenue Form 62A850, "Bank Deposits Tax Return", August 2013[2011];
166.[164.] Revenue Form 62A862, "Certification of Tax Rate for Bank Deposits Franchise Tax", August 2011;
167.[165.] Revenue Form 62A863, "Financial Institutions Local Deposits Summary Report", August 2013[2011];
168.[166.] Revenue Form 62A863-A, "Schedule A, Summary of Net Deposits", August 2013[2011];
169.[167.] Revenue Form 62A880, "Personal Property Assessment", October 2004;
170.[168.] Revenue Form 62B003, "Unmined Coal Notice of Tax Assessment", November 2008;
171.[169.] Revenue Form 62B011, "Limestone, Sand, or Gravel Assessment Notice", July 2006;
172.[170.] Revenue Form 62B012, "Oil Assessment Notice", July 2006;
173.[171.] Revenue Form 62B013, "Clay Assessment Notice", July 2006;
174.[172.] Revenue Form 62B015, "Gas Assessment Notice", July 2006;
175.[173.] Revenue Form 62F003, "Appeals Process for Real Property Assessments", May 2009;
176.[174.] Revenue Form 62F015, "PVA Open Records Commercial Fee Guidelines", August 2012;
177.[175.] Revenue Form 62F031, "Appeal to Local Board of Assessment Appeals", January 2010;
178.[176.] Revenue Form 62F200, "Important Reminder", January 2014[2013];
179.[177.] Revenue Form 62F384-G, "Important Reminder", January 2014[2013];
180.[178.] Revenue Form 62F500, "Important Reminder", December 2013[2012]; and
181.[179.] Revenue Form 62F1341, "Exemptions Allowed for Savings and Loans, Savings Banks and Similar Institutions for Intangible Property Tax Purposes", August 2011; and
 (b) Severance taxes - referenced material:
 1. Revenue Form 10A100, "Kentucky Tax Registration Application", July 2013[August 2012];
 2. Revenue Form 10A104, "Update or Cancellation of Kentucky Account(s)", June 2011;
 3. Revenue Form 55A004, "Coal Severance Tax Seller/Purchaser Certificate", October 2010;
 4. Revenue Form 55A100, "Coal Severance Tax Return", October 2010;

5. Revenue Form 55A100, "Part IV - Schedule of Purchased Coal" and "Part V - Schedule for Thin Seam Coal Tax Credit", October 2010;

6. Revenue Form 55A101, "Coal Severance Tax Return Instructions", October 2010;

7. Revenue Form 55A131, "Credit Memorandum", December 2006;

8. Revenue Form 55A209, "Severance Tax Refund Application", August 2009;

9. Revenue Form 56A001, "Application for Certificate of Registration Minerals and Natural Gas Tax", October 1984;

10. Revenue Form 56A100, "Natural Gas and Natural Gas Liquids Tax Return", July 2004;

11. Revenue Form 56A101, "Minerals Tax Return", July 2004;

12. Revenue Form 56A106, "Minerals Tax Certificate of Exemption", December 2006;

13. Revenue Form 56A107, "Schedule A, Allocation of Gross Value of Minerals Severed in Kentucky and Schedule B, Minerals Purchased from Others for Processing by Taxpayer", January 2005;

14. Revenue Form 56A108, "Schedule A, Gross Value of Natural Gas Sold to Nonconsumers and Schedule B, Taxable Gross Value of Natural Gas and Natural Gas Liquids Extracted in Kentucky by Taxpayer - Allocation", March 2005;

15. Revenue Form 56A109, "Schedule C, Natural Gas First Purchased by Taxpayer from Kentucky Producers", January 2005;

16. Revenue Form 56A110, "Minerals Tax Return Attachment, Schedule C, Computation of Clay Severed and Processed in Kentucky and Allocation of Tax Attributable to Clay", March 2005;

17. Revenue Form 56A112, "Crude Petroleum Transporter's Monthly Report, Kentucky Oil Production Tax", July 2004;

18. Revenue Form 56A113, "Minerals Tax Credit for Limestone Sold in Interstate Commerce", November 1997; and

19. Revenue Form 56A114, "Crude Petroleum Transporter's Application for Registration", December 2006.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40620, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21st, 2014 from 10:00 a.m. till 12:00 p.m. in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend this hearing was 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 February 28th, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Office of General Counsel, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9526, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by promulgation of an administrative regulation incorporating the

forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of Property and Severance Taxes by the Department of Revenue.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order for the Department of Revenue to meet the requirements of KRS Chapter 13A.110 which requires that forms required to be submitted by a regulated entity shall be included in an administrative regulation.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required revenue forms used in the administration of Property and Severance Taxes by the Department of Revenue.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation incorporates by reference the required forms used in the administration of Property and Severance Taxes by the Department of Revenue.

(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 contains tax forms to be used for tax year 2014.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to update tax forms for the tax year 2014.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of the tax laws.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide taxpayers with the necessary tax forms to file and pay personal tangible and public service property taxes for tax years beginning in 2014.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All Kentucky taxpayers and their representatives will be affected by the listing of forms administered by the Department of Revenue in an administrative regulation. Local government will be affected to the extent they utilize forms administered by the Department of Revenue. The Department of Revenue will be affected to the extent that it administers the referenced forms.

(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: As forms are changed, the manuals and the Department of Revenue Website in which copies of all forms listed in this regulation are maintained will be updated.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): All taxpayers and the administering agencies will benefit by having access to a centralized listing of the most current forms in use.

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

(a) Initially: The Department of Revenue will not incur additional cost as the result of this regulation.

(b) On a continuing basis: The Department of Revenue will not incur additional costs as the result of this regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Department of Revenue agency funds.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: This administrative regulation does not require an increase in fees or funding.

(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 either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not applied because the requirements of this regulation apply to every taxpayer.

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 Finance and Administration Cabinet, Department of Revenue, Office of Property Valuation, Local Valuation Branch, State Valuation Branch and Mineral/GIS Services Branch.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 131.130(1)

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? The administrative cost will be absorbed in the normal operating cost of the department.

(d) How much will it cost to administer this program for subsequent years? The administrative cost will be absorbed in the normal operating budget of the department.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

FINANCE AND ADMINISTRATION CABINET

Department of Revenue

Office of Income Taxation

(Amendment)

103 KAR 3:040. Income Tax Forms Manual.

RELATES TO: KRS 131.041, 131.051, 131.061, 131.071, 131.081, 131.110, 131.130, 131.155, 131.170, 131.180, 131.190, 131.250, 131.340, 131.500, 131.510(1), (2)(a), 131.540, 141.010, 141.0101, 141.011, 141.016, 141.020, 141.0202, 141.030, 141.040, 141.0401, 141.0405, 141.041, 141.042, 141.044, 141.062, 141.065, 141.066, 141.067, 141.068, 141.069, 141.070, 141.071, 141.120, 141.121, 141.160, 141.170, 141.180, 141.200, 141.205, 141.206, 141.207, 141.208, 141.300, 141.310, 141.325, 141.330, 141.335, 141.347, 141.370, 141.381, 141.382, 141.383, 141.384, 141.385, 141.386, 141.390, 141.392, 141.395, 141.400, 141.401, 141.402, 141.403, 141.405, 141.407, 141.412, 141.415, 141.418, 141.420, 141.421, 141.423, 141.424, 141.4242, 141.4244, 141.428, 141.430, 141.434, 141.436, 141.437, 141.438, 141.985, 141.990, 151B.127, 154.12-2086, 154.20-050, 154.22-060, 154.23-035, 154.24-110, 154.25-030, 154.26-090, 154.28-090, 154.32-010, 154.34-080, 154.45-090, 154.48-025, 155.170

STATUTORY AUTHORITY: KRS 131.130(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 131.130(3) authorizes the Department of Revenue to prescribe forms necessary for the administration of any revenue law by the promulgation of an administrative regulation incorporating the forms by reference. This administrative regulation incorporates by reference the required Revenue forms used in the administration of income taxes by the Department of Revenue.

Section 1. Corporation Income Taxes. (1) Revenue Form 41A720, "Form 720, 2013[2012] Kentucky Corporation Income Tax and LLET Return", shall be used by a C corporation to determine its corporation income tax due in accordance with KRS 141.040 and its limited liability entity tax due in accordance with KRS 141.0401 for tax years beginning in 2013[2012].

(2) Revenue Form 41A720A, "Schedule A, Apportionment and Allocation (For corporations and pass-through entities taxable both within and without Kentucky)", shall be used by a corporation or a pass-through entity taxable both within and without Kentucky to apportion and allocate its net income to Kentucky in accordance with KRS 141.120 or 141.206.

(3) Revenue Form 41A720A-C, "Schedule A-C, Apportionment and Allocation - Continuation Sheet (For corporations and pass-through entities taxable both within and without Kentucky)", shall be used by a corporation or a pass-through entity taxable both within and without Kentucky that is also a partner or member of a pass-through entity to determine the sales, property and payroll amounts to be entered on Revenue Form 41A720A.

(4) Revenue Form 41A720A-N, "Schedule A-N, Apportionment Factor Schedule (For a Nexus Consolidated Tax Return)", shall be used by a corporation filing a mandatory nexus consolidated return to show the Kentucky and total sales, property, and payroll of the corporation and each subsidiary included in the apportionment factor.

(5) Revenue Form 41A720BIO, "Schedule BIO, Application and Credit Certificate of Income Tax/LLET Credit Biodiesel", shall be used by a taxpayer who is a biodiesel producer, biodiesel blender, or renewable diesel producer to report the biodiesel gallons produced or used by the blender and request approval from the Kentucky Department of Revenue of the tax credit amount allowed by KRS 141.423.

(6) Revenue Form 41A720CC, "Schedule CC, Coal Conversion Tax Credit", shall be used by a corporation to compute the tax credit allowed by KRS 141.041 for coal used or substituted for other fuels in an eligible heating facility as described by KRS 141.041(1).

(7) Revenue Form 41A720-CCI, "Schedule CCI, Application and Credit Certificate of Clean Coal Incentive Tax Credit", shall be used by a taxpayer to request approval from the Department of Revenue of the tax credit amount allowed by KRS 141.428 for the purchase of Kentucky coal used by the taxpayer to generate electricity.

(8) Revenue Form 41A720CELL, "Schedule CELL, Application and Credit Certificate of Income Tax/LLET Credit Cellulosic Ethanol", shall be used by a taxpayer who is a producer of cellulosic ethanol to report the number of cellulosic ethanol gallons and request approval from the Department of Revenue of the tax credit amount allowed by KRS 141.4244.

(9) Revenue Form 41A720-CI, "Schedule CI, Application for Coal Incentive Tax Credit", shall be used by a taxpayer to request approval for the amount of tax credit allowed by KRS 141.0405 for the purchase of Kentucky coal used by the taxpayer to generate electricity.

(10) Revenue Form 41A720COGS, "Schedule COGS, Limited Liability Entity Tax Cost of Goods Sold", shall be used by a taxpayer to compute its Kentucky cost of goods sold and its total costs of goods sold from all sources for purposes of computing its limited liability entity tax based on gross profits.

(11) Revenue Form 41A720CR, "Schedule CR, Pro Forma Federal Consolidated Return Schedule", shall be used by a C corporation filing a consolidated return to show its federal pro forma consolidated return.

(12)(14) Revenue Form 41A720CR-C, "Schedule CR-C, Pro

Forma Federal Consolidated Return Schedule Continuation Sheet", shall be used by a C corporation filing a consolidated return as a continuation of Revenue Form 41A720CR.

~~(13)[(12)]~~ Revenue Form 41A720ES, "Form 720-ES Kentucky, 2014[2013] Corporation Income/Limited Liability Entity Tax Estimated Tax Voucher", shall be used by a corporation or a limited liability pass-through entity to submit payments of estimated corporation income or limited liability entity tax as required by KRS 141.044.

~~(14)[(13)]~~ Revenue Form 41A720ETH, "Schedule ETH, Application and Credit Certificate of Income Tax/LLET Credit Ethanol", shall be used by a taxpayer who is a producer of ethanol to report ethanol gallons produced and request approval from the Kentucky Department of Revenue of the tax credit amount allowed by KRS 141.4242.~~[(14) Revenue Form 41A720EZC, "Schedule EZC, Enterprise Zone Tax Credit", shall be used by a qualified taxpayer to determine the tax credit allowed by KRS 154.45-090.]~~

~~(15) Revenue Form 41A720FD, "Schedule FD, Food Donation Tax Credit", shall be used by a taxpayer who provides edible agricultural products to a nonprofit food program operating in Kentucky to determine the credit allowed by KRS 141.392.~~

~~(16) Revenue Form 41A720HH, "Schedule HH, Kentucky Housing for Homeless Families Deduction", shall be used by an individual, corporation, fiduciary, or pass-through entity to determine the deduction allowed by KRS 141.0202.~~

~~(17)[(16)]~~ Revenue Form 41A720(I), "Instructions, 2013[2012] Kentucky Corporation Income Tax and LLET Return", shall be used by a corporation to file its 2013[2012] Kentucky Corporation Income Tax and LLET Return and related schedules.

~~(18)[(17)]~~ Revenue Form 41A720KCR, "Schedule KCR, Kentucky Consolidated Return Schedule", shall be used by a C corporation filing a nexus consolidated return showing the income or loss of each entity included in the nexus consolidated tax return.

~~(19)[(18)]~~ Revenue Form 41A720KCR-C, "Schedule KCR-C, Kentucky Consolidated Return Schedule - Continuation Sheet", shall be used by a C corporation filing a nexus consolidated return as a continuation of Revenue Form 41A720KCR.

~~(20)[(19)]~~ Revenue Form 41A720KESA, "Schedule KESA, Tax Credit Computation Schedule (For a KESA Project of a Corporation)", shall be used by a corporation which has entered into an agreement for a Kentucky Environmental Stewardship Act (KESA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.430.

~~(21)[(20)]~~ Revenue Form 41A720KESA-SP, "Schedule KESA-SP, Tax Credit Computation Schedule (For a KESA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into an agreement for a Kentucky Environmental Stewardship Act (KESA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.430.

~~(22)[(21)]~~ Revenue Form 41A720KESA-T, "Schedule KESA-T, Tracking Schedule for a KESA Project", shall be used by a company which has entered into an agreement for a Kentucky Environmental Stewardship Act (KESA) project to maintain a record of the approved costs and tax credits for the duration of the agreement.

~~(23)[(22)]~~ Revenue Form 41A720LLET, "Schedule LLET, Limited Liability Entity Tax", shall be used by a corporation or a limited liability pass-through entity to determine the limited liability entity tax in accordance with KRS 141.0401.

~~(24)[(23)]~~ Revenue Form 41A720LLET-C, "Schedule LLET-C, Limited Liability Entity Tax - Continuation Sheet", shall be used by a corporation or a limited liability pass-through entity that is a partner in a general partnership organized or formed as a general partnership after January 1, 2006, or a partner or member in a limited liability pass-through entity to determine its Kentucky gross receipts and Kentucky gross profits and its total gross receipts and total gross profits from all sources to be entered on Revenue Form 41A720LLET.

~~(25)[(24)]~~ Revenue Form 41A720LLET(K), "Schedule LLET(K), Limited Liability Entity Tax (For a Limited Liability Pass-through Entity with Economic Development Project(s))", shall be used by

limited liability pass-through entities with economic development projects to determine the limited liability entity tax in accordance with KRS 141.0401.

~~(26)[(25)]~~ Revenue Form 41A720LLET(K)-C, "Schedule LLET(K)-C, Limited Liability Entity Tax - Continuation Sheet (For a Limited Liability Pass-Through Entity with Economic Development Projects)", shall be used by a limited liability pass-through entity with an economic development project that is a partner or member of a limited liability pass-through entity or a general partnership organized or formed as a general partnership after January 1, 2006, to determine its Kentucky gross receipts and Kentucky gross profits and its total gross receipts and total gross profits from all sources to be entered on Revenue Form 41A720LLET(K).

~~(27)[(26)]~~ Revenue Form 41A720NOL, "Schedule NOL, Net Operating Loss Schedule", shall be used by a C corporation with a current year net operating loss or net operating loss carry-forward.

~~(28)[(27)]~~ Revenue Form 41A720NOL-CF, "Schedule NOL-CF, Kentucky NOL Carry forward Schedule", shall be used by a corporation filing a nexus consolidated income tax return as provided by KRS 141.200, in addition to Revenue Form 41A720NOL, to show the Kentucky net operating loss (KNOL) carry forward balance for each new member of the affiliated group.

~~(29)[(28)]~~ Revenue Form 41A720-O, "Schedule O-720, Other Additions and Subtractions To/From Federal Taxable Income", shall be used by a corporation filing Kentucky Form 720 to show other additions to and subtractions from federal taxable income on Revenue Form 41A720, Part III, Lines 9 and 16, respectively.

~~(30)[(29)]~~ Revenue Form 41A720QR, "Schedule QR, Qualified Research Facility Tax Credit", shall be used by a corporation, individual, or pass-through entity to determine the credit against the income tax liability or LLET liability allowed by KRS 141.395.

~~(31)[(30)]~~ Revenue Form 41A720RC, "Schedule RC, Application for Income Tax/LLET Credit for Recycling and/or Composting Equipment or Major Recycling Project", shall be used by a taxpayer to request approval for the amount of credit allowed by KRS 141.390 for the purchase and installation of recycling or composting equipment or a major recycling project. This form shall also be used by an individual, corporation, fiduciary, or pass-through entity to substantiate and keep a record of the amount of approved credit claimed on their tax return.

~~(32)[(31)]~~ Revenue Form 41A720RC-C, "Schedule RC-C, Schedule RC - Part I Continuation", shall be used by an individual, corporation, fiduciary, or pass-through entity, in addition to Revenue Form 41A720RC, to list additional equipment for which approval of the credit allowed by KRS 141.390 is being requested.

~~(33)[(32)]~~ Revenue Form 41A720RC(I), "Instructions for Schedule RC", shall be used by taxpayers filing Revenue Form 41A720RC and Revenue Form 41A720RC-C requesting approval of a tax credit for recycling equipment, composting equipment, or a major recycling project.

~~(34)[(33)]~~ Revenue Form 41A720RC-R, "Schedule RC-R, Recycling or Composting Equipment Tax Credit Recapture", shall be used by a taxpayer disposing of recycling or composting equipment before the end of the recapture period to compute the tax credit recaptured to be reported on the applicable tax return.

~~(35)[(34)]~~ Revenue Form 41A720RPC, "Schedule RPC, Related Party Costs Disclosure Statement," shall be used by an entity to report related party expenses and the exceptions to the required disallowance of related party expenses as provided by KRS 141.205.

~~(36)[(35)]~~ Revenue Form 41A720RR-E, "Schedule RR-E, Application and Credit Certificate of Income Tax/LLET Credit Railroad Expansion", shall be used by a corporation or pass-through entity requesting approval of a railroad expansion tax credit allowed by KRS 141.386.

~~(37)[(36)]~~ Revenue Form 41A720RR-I, "Schedule RR-I, Railroad Maintenance and Improvement Tax Credit", shall be used by a corporation, individual, or pass-through entity to determine the credit against the income tax liability or LLET liability allowed by KRS 141.385.

~~(38)[(37)]~~ Revenue Form 41A720S, "Form 720S, 2013[2012] Kentucky S Corporation Income Tax and LLET Return", shall be used by an S corporation to determine the amount of tax due in

accordance with KRS 141.040 and 141.0401 and to report the shareholders' share of income, loss, credits, deductions, etc. for tax years beginning in ~~2013~~2012.

~~(39)~~(38) Revenue Form 41A720S(I), "Instructions, ~~2013~~2012 Kentucky S Corporation Income Tax and LLET Return", shall be used by an S corporation to file its ~~2013~~2012 Kentucky S Corporation Income Tax and LLET Return and related schedules.

~~(40)~~(39) Revenue Form 41A720S(K), "Form 720S(K), Kentucky Schedule K for S Corporations With Economic Development Project(s)", shall be used for tax years beginning in ~~2013~~2012 by S Corporations with economic development projects to determine the shareholders' shares of income, credit, deductions, etc., excluding the economic development projects.

~~(41)~~(40) Revenue Form 41A720S(K-1), "Schedule K-1 (Form 720S), ~~2013~~2012 Shareholder's Share of Income, Credits, Deductions, Etc.", shall be used by an S corporation to report to each of its shareholders the amount of income, credit, deduction, etc., that the shareholder shall report for Kentucky income tax purposes.

~~(42)~~(41) Revenue Form 41A720S-O, "Schedule O-PTE, Other Additions and Subtractions To/From Federal Ordinary Income", shall be used by a pass-through entity filing Revenue Form 41A720S, Form 41A765, or Form 42A765-GP to show other additions to and subtractions from federal ordinary income on Revenue Form 41A720S, 41A765, or 42A765-GP Part I, Lines 5 and 9, respectively.

~~(43)~~(42) Revenue Form 41A720SL, "Application for Six-Month Extension of Time to File Kentucky Corporation or Limited Liability Pass-Through Entity Return", shall be used by a corporation or a limited liability pass-through entity to request a six (6) month extension of time to file a tax return or an LLET return or to submit payment of unpaid tax.

~~(44)~~(43) Revenue Form 41A720TCS, "Schedule TCS, Tax Credit Summary Schedule", shall be used by a corporation or a limited liability pass-through entity to summarize tax credits claimed and shall be attached to the tax return.

~~(45)~~(44) Revenue Form 41A720VERB, "Schedule VERB, Voluntary Environmental Remediation Tax Credit", shall be used by an entity claiming a tax credit provided by KRS 141.418.

~~(46)~~(45) Revenue Form 41A720-S1, "Form 720X, Amended Kentucky Corporation Income Tax and Corporation License Tax Return", shall be used by a C corporation to amend its Kentucky Corporation Income and License Tax Return for tax periods beginning prior to January 1, 2005, as previously filed.

~~(47)~~(46) Revenue Form 41A720-S2, "Form 720-AMENDED, Amended Kentucky Corporation Income Tax Return", shall be used by a C corporation to amend its Kentucky Corporation Income Tax Return for periods beginning on or after January 1, 2005 and before January 1, 2007, as previously filed.

~~(48)~~(47) Revenue Form 41A720-S3, "Form 720-AMENDED (2007-2008), Amended Kentucky Corporation Income Tax and LLET Return", shall be used by a C corporation to amend its Kentucky Corporation Income Tax and LLET Return for periods beginning on or after January 1, 2007 and before January 1, 2009, as previously filed.

~~(49)~~(48) Revenue Form 41A720-S4, "Form 851-K, Kentucky Affiliations and Payment Schedule", shall be used by a corporation filing a consolidated Kentucky income tax return on Revenue Form 41A720 to identify the members of the affiliated group which are subject to the Kentucky corporation tax and to list the amount of tax paid.

~~(50)~~(49) Revenue Form 41A720-S6, "Form 2220-K, Underpayment and Late Payment of Estimated Income Tax and LLET", shall be used by a corporation or limited liability pass-through entity required by KRS 141.042 and 141.044 to file a declaration of estimated tax, to compute the underpayment penalty as provided by KRS 131.180(3) and 141.990, and to compute the interest on any late payment or underpayment of an estimated tax installment as provided by ~~KRS 131.183(2) and~~ 141.985.

~~(51)~~(50) Revenue Form 41A720-S7, "Form 5695-K, Kentucky Energy Efficiency Products Tax Credit", shall be used by a taxpayer to claim a tax credit for installation of energy efficiency products for residential and commercial property as provided by

KRS 141.436.

~~(52)~~ Revenue Form 41A720-S8, "Form 8879(C) – K, Kentucky Corporation or Pass-Through Entity Tax Return Declaration for Electronic Filing", shall be used by a taxpayer as a declaration document and signature authorization for an electronic filing of a Kentucky income or LLET return.

~~(53)~~(51) Revenue Form 41A720-S9, "Form 8903-K, Kentucky Domestic Production Activities Deduction", shall be used by a corporation to determine the Domestic Production Activities Deduction amount for Kentucky corporation income tax purposes and shall be attached to the corporation income tax return.

~~(54)~~(52) Revenue Form 41A720-S11, "Form 8908-K, Kentucky ENERGY STAR (Homes and Manufactured Homes) Tax Credit", shall be used by a taxpayer to claim a tax credit for the construction of an ENERGY STAR home or the sale of an ENERGY STAR manufactured home as provided by KRS 141.437.

~~(55)~~ Revenue Form 41A720-S12, "Form 720-V, Electronic Filing Payment Voucher", shall be used by an entity filing an electronic Kentucky tax return to pay the balance of tax due.

~~(56)~~(53) Revenue Form 41A720-S16, "Schedule KREDA, Tax Credit Computation Schedule (For a KREDA Project of a Corporation)", shall be used by a corporation which has a Kentucky Rural Economic Development Act (KREDA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.347.

~~(57)~~(54) Revenue Form 41A720-S17, "Schedule KREDA-T, Tracking Schedule for a KREDA Project", shall be used by a company which has a Kentucky Rural Economic Development Act (KREDA) project to maintain a record of the debt service payments, wage assessment fees and tax credits for the duration of the project.

~~(58)~~(55) Revenue Form 41A720-S18, "Schedule KREDA-SP, Tax Computation Schedule (For a KREDA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Rural Economic Development Act (KREDA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.347.

~~(59)~~(56) Revenue Form 41A720-S20, "Schedule KIDA, Tax Credit Computation Schedule (For a KIDA Project of a Corporation)", shall be used by a corporation which has a Kentucky Industrial Development Act (KIDA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.400.

~~(60)~~(57) Revenue Form 41A720-S21, "Schedule KIDA-T, Tracking Schedule for a KIDA Project", shall be used by a company which has a Kentucky Industrial Development Act (KIDA) project to maintain a record of the debt service payments and tax credits for the duration of the project.

~~(61)~~(58) Revenue Form 41A720-S22, "Schedule KIDA-SP, Tax Computation Schedule (For a KIDA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Industrial Development Act (KIDA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.400.

~~(62)~~(59) Revenue Form 41A720-S24, "Schedule KIRA, Tax Credit Computation Schedule (For a KIRA Project of a Corporation)", shall be used by a corporation which has a Kentucky Industrial Revitalization Act (KIRA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.403.

~~(63)~~(60) Revenue Form 41A720-S25, "Schedule KIRA-T, Tracking Schedule for a KIRA Project", shall be used by a company which has a Kentucky Industrial Revitalization Act (KIRA) project to maintain a record of the approved costs, wage assessment fees and tax credits for the duration of the project.

~~(64)~~(61) Revenue Form 41A720-S26, "Schedule KIRA-SP, Tax Computation Schedule (For a KIRA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Industrial Revitalization Act (KIRA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.403.

~~(65)~~~~(62)~~ Revenue Form 41A720-S27, "Schedule KJDA, Tax Credit Computation Schedule (For a KJDA Project of a Corporation)", shall be used by a corporation which has a Kentucky Jobs Development Act (KJDA) project to determine the credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.407.

~~(66)~~~~(63)~~ Revenue Form 41A720-S28, "Schedule KJDA-T, Tracking Schedule for a KJDA Project", shall be used by a company which has a Kentucky Jobs Development Act (KJDA) project to maintain a record of the approved costs, wage assessment fees, in-lieu-of credits and tax credits for the duration of the project.

~~(67)~~~~(64)~~ Revenue Form 41A720-S29, "Schedule KJDA-SP, Tax Computation Schedule (For a KJDA Project of a Pass-Through Entity)" shall be used by a pass-through entity which has a Kentucky Jobs Development Act (KJDA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.407.

~~(68)~~~~(65)~~ Revenue Form 41A720-S35, "Schedule KRA, Tax Credit Computation Schedule (For a KRA Project of a Corporation)", shall be used by a corporation which has entered into a Kentucky Reinvestment Act (KRA) project to compute the allowable KRA credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

~~(69)~~~~(66)~~ Revenue Form 41A720-S36, "Schedule KRA-SP, Tax Computation Schedule (For a KRA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Kentucky Reinvestment Act (KRA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

~~(70)~~~~(67)~~ Revenue Form 41A720-S37, "Schedule KRA-T, Tracking Schedule For a KRA Project", shall be used by a company which has entered into a Kentucky Reinvestment Act (KRA) project to maintain a record of the balance of approved costs and tax credits for the duration of the agreement.

~~(71)~~~~(68)~~ Revenue Form 41A720-S40, "Schedule KEOZ, Tax Credit Computation Schedule (For a KEOZ Project of a Corporation)", shall be used by a corporation which has entered into a Kentucky Economic Opportunity Zone (KEOZ) Act project to compute the allowable KEOZ credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.401.

~~(72)~~~~(69)~~ Revenue Form 41A720-S41, "Schedule KEOZ-SP, Tax Computation Schedule (For a KEOZ Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into a Kentucky Economic Opportunity Zone (KEOZ) Act project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.401.

~~(73)~~~~(70)~~ Revenue Form 41A720-S42, "Schedule KEOZ-T, Tracking Schedule for a KEOZ Project", shall be used by a company which has entered into an agreement for a Kentucky Economic Opportunity Zone (KEOZ) Act project to maintain a record of the debt service payments, wage assessment fees, approved costs and tax credits for the duration of the agreement.

~~(74)~~~~(71)~~ Revenue Form 41A720-S45, "Schedule KJRA, Tax Credit Computation Schedule (For a KJRA Project of a Corporation)", shall be used by a company which has entered into a Kentucky Jobs Retention Act (KJRA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.402.

~~(75)~~~~(72)~~ Revenue Form 41A720-S46, "Schedule KJRA-T, Tracking Schedule For a KJRA Project", shall be used by a company which has entered into an agreement for a Kentucky Jobs Retention Act (KJRA) project to maintain a record of the debt service payments, wage assessment fees, approved costs, and tax credits for the duration of the agreement.

~~(76)~~~~(73)~~ Revenue Form 41A720-S47, "Schedule KJRA-SP, Tax Computation Schedule (For a KJRA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into a Kentucky Jobs Retention Act (KJRA) project to determine the credit allowed against its Kentucky income tax liability and

limited liability entity tax liability in accordance with KRS 141.402.

~~(77)~~~~(74)~~ Revenue Form 41A720-S50, "Schedule IEIA, Tax Credit Computation Schedule (For an IEIA Project of a Corporation)", shall be used by a company which has entered into an Incentives for Energy Independence Act (IEIA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.421.

~~(78)~~~~(75)~~ Revenue Form 41A720-S51, "Schedule IEIA-T, Tracking Schedule for an IEIA Project", shall be used by a company which has entered into an Incentives for Energy Independence Act (IEIA) project to maintain a record of the balance of approved costs, wage assessments, and tax credits for the duration of the agreement.

~~(79)~~~~(76)~~ Revenue Form 41A720-S52, "Schedule IEIA-SP, Tax Computation Schedule (For an IEIA Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into an Incentives for Energy Independence Act (IEIA) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.421.

~~(80)~~~~(77)~~ Revenue Form 41A720-S53, "Schedule KBI, Tax Credit Computation Schedule (For a KBI Project of a Corporation)", shall be used by a corporation which has entered into a Kentucky Business Investment (KBI) project to compute the allowable KBI credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

~~(81)~~~~(78)~~ Revenue Form 41A720-S54, "Schedule KBI-SP, Tax Computation Schedule (For a KBI Project of a Pass-Through Entity)", shall be used by a pass-through entity which has entered into a Kentucky Business Investment (KBI) project to determine the credit allowed against its Kentucky income tax liability and limited liability entity tax liability in accordance with KRS 141.415.

~~(82)~~~~(79)~~ Revenue Form 41A720-S55, "Schedule KBI-T, Tracking Schedule for a KBI Project", shall be used by a company which has entered into an agreement for a Kentucky Business Investment (KBI) project to maintain a record of approved costs, wage assessments, and tax credits for the duration of the agreement.

~~(83)~~ Revenue Form 41A720-S56, "Schedule FON, Tax Credit Computation Schedule (For a FON project of a corporation)", shall be used by a corporation which has a Farm Operation Networking Project (FON) to compute the allowable FON credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.412.

~~(84)~~ Revenue Form 41A720-S57, "Schedule FON-SP, Tax Computation Schedule (For a FON project of a Pass-Through Entity)", shall be used by a pass-through entity which has a Farm Operation Networking Project (FON) to determine the allowable FON credit allowed against its Kentucky corporation income tax liability and limited liability entity tax liability in accordance with KRS 141.412.

~~(85)~~ Revenue Form 41A720-S58, "Schedule FON-T, Tracking Schedule for a FON Project", shall be used by a company with a Farm Operation Networking Project (FON) to maintain a record of approved costs and the tax credits taken for the duration of the project.

~~(86)~~~~(80)~~ Revenue Form 41A720-S80, "Form 8874(K), Application for Certification of Qualified Equity Investments Eligible for Kentucky New Markets Development Program Tax Credit", shall be used by a qualified community development entity that seeks to have an equity investment or long-term debt security certified as a qualified equity investment eligible for the tax credit provided by KRS 141.434.

~~(87)~~~~(81)~~ Revenue Form 41A720-S81, "Form 8874(K)-A, Notice of Kentucky New Markets Development Program Tax Credit and Certification", shall be used by a qualified community development entity to provide proof to the Kentucky Department of Revenue of the receipt of cash for a taxpayer's qualified equity investment.

~~(88)~~~~(82)~~ Revenue Form 41A720-S82, "Form 8874(K)-B, Notice of Kentucky New Markets Development Program Tax Credit

Recapture", shall be used by the Kentucky Department of Revenue to notify a taxpayer of a recapture of the New Markets Development Program tax credit.

(89)[(83)] Revenue Form 41A725, "Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", shall be used by a single member individually-owned LLC to file an LLET return in accordance with KRS 141.0401 for tax years beginning in 2013[2012].

(90)[(84)] Revenue Form 41A725CP, "Schedule CP, Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned Composite Return Schedule", shall be used by a single member individual with multiple LLC entities to file LLET returns in accordance with KRS 141.0401 for tax years beginning in 2013[2012].

(91)[(85)] Revenue Form 41A725(I), "Instructions, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", shall be used by a single member LLC individually owned to file its 2013[2012] Kentucky LLET return and related schedules.

(92)[(86)] Revenue Form 41A750, "Form 750, Business Development Corporation Tax Return", shall be used by a corporation organized under the provisions of KRS Chapter 155 to determine its excise tax due in accordance with KRS 155.170 for tax years beginning in 2013[2012].

(93)[(87)] Revenue Form 41A765, "Form 765, 2013[2012] Kentucky Partnership Income and LLET Return", shall be used by an entity taxed as a partnership and organized as a LLC, LLP or LP to file its Kentucky income and LLET return in accordance with KRS 141.0401 and 141.206 for tax years beginning in 2013[2012].

(94)[(88)] Revenue Form 41A765(I), "Instructions, 2013[2012] Kentucky Partnership Income and LLET Return", shall be used by an entity taxed as a partnership and organized as a LLC, LLP, or LP to file its 2013[2012] Kentucky income and LLET return and related schedules.

(95)[(89)] Revenue Form 41A765(K), "Form 765(K), Kentucky Schedule K For Partnerships With Economic Development Project(s)", shall be used for tax years beginning in 2013[2012] by partnerships with economic development projects to determine the partners' share of income, credits, deductions, etc., excluding the economic development projects.

(96)[(90)] Revenue Form 41A765(K-1), "Schedule K-1 (Form 765), 2013[2012] Partner's Share of Income, Credits, Deductions, Etc.", shall be used by an entity taxed as a partnership and organized as a LLC, LLP, or LP to report to its partners the amount of income, credit, deduction, etc., that the partners shall report for Kentucky income tax purposes.

(97)[(91)] Revenue Form 41A800, "Corporation and Pass-through Entity Nexus Questionnaire", shall be used by a corporation or pass-through entity to determine if the entity has nexus with the Commonwealth of Kentucky.

(98)[(92)] Revenue Form 41A802, "Corporation and Pass-through Entity Related Party Expense Questionnaire", shall be used by a corporation or pass-through entity to determine if the entity has nondeductible related party expense.

Section 2. Individual Income and Withholding Taxes. (1) Revenue Form 12A200, "Kentucky Individual Income Tax Installment Agreement Request", shall be submitted to the Department of Revenue to request an installment agreement to pay tax due.

(2) Revenue Form 40A100, "Application for Refund of Income Taxes", shall be presented to the Department of Revenue to request a refund of income taxes paid.

(3) Revenue Form 40A102, "2013[2012] Application for Extension of Time to File Individual, General Partnership and Fiduciary Income Tax Returns for Kentucky", shall be submitted to the Department of Revenue by individuals, partnerships, and fiduciaries prior to the date prescribed by law for filing a return to request a six (6) month extension to file the return or to remit payment of tax prior to the date the return is due.

(4) Revenue Form 40A103, "Application for New Home Tax Credit", shall be submitted to the Department of Revenue by individuals to request approval for the new home tax credit.

(5) Revenue Form 40A200, "Form PTE-WH, Kentucky

Nonresident Income Tax Withholding on Distributive Share Income", shall be used by a pass-through entity doing business in Kentucky to report Kentucky income tax withheld on each nonresident individual or corporate partner doing business in Kentucky only through its ownership interest in the pass-through entity.

(6) Revenue Form 40A201, "Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return", shall be used by a pass-through entity doing business in Kentucky to report and pay Kentucky income tax withheld on nonresident individual and corporate partners.

(7) Revenue Form 40A201ES, "Form 740NP-WH-ES, Instructions – 2014[2013] Pass-Through Entity Nonresident Distributive Share Withholding Report and Composite Income Tax Return Voucher", shall be used by every pass-through entity for the declaration and payment of estimated tax if required.

(8) Revenue Form 40A201NP-WH-SL, "Form 740NP-WH-SL, Application for Six-Month Extension of Time to File Form 740NP-WH", shall be used by a pass-through entity to request a six (6)-month extension to file Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return.

(9) Revenue Form 40A201-WHP, "Form 740NP-WH-P, Underpayment and Late Payment of Estimated Tax on Form 740NP-WH", shall be used by a pass-through entity to compute the interest and penalty on the underpayment and late payment of estimated tax on Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return.

(10) Revenue Form 40A727, "Kentucky Income Tax Forms Requisition", shall be used by a taxpayer or tax preparer to order individual income tax forms.

(11) Revenue Form 42A003, "Withholding Kentucky Income Tax Instructions for Employers", shall provide instructions for employers and shall contain forms used for withholding and reporting Kentucky income tax withholding.

(12) Revenue Form 42A003(T), "2014[2013] Withholding Tax Tables Computer Formula", shall be used by an employer for computing employees' Kentucky income tax withholding each pay period.

(13) Revenue Form 42A740, "Form 740, 2013[2012] Kentucky Individual Income Tax Return, Full-Year Residents Only", shall be completed by a resident individual to report taxable income and income tax liability for taxable years beginning in 2013[2012], and shall be due within three and one-half (3 1/2) months after the close of the taxable year.

(14) Revenue Form 42A740-A, "Schedule A, Form 740, 2013[2012] Kentucky Itemized Deductions", shall be completed by resident individuals and attached to Form 740 to support itemized deductions claimed for 2013[2012].

(15) Revenue Form 42A740ES, "Form 740-ES, 2014[2013] Individual Income Tax Kentucky Estimated Tax Voucher", shall be submitted to the Department of Revenue by individuals with payment of quarterly estimated tax.

(16) Revenue Form 42A740-EZ, "Form 740-EZ, 2013[2012] Kentucky Individual Income Tax Return for Single Persons with No Dependents", shall be completed by resident individuals to report taxable income and income tax liability for taxable years beginning in 2013[2012], and shall be due within three and one-half (3 1/2) months after the close of the taxable year.

(17) Revenue Form 42A740(I), "2013[2012] Kentucky Individual Income Tax Instructions for Forms 740 and 740-EZ", shall be used by resident individuals to file the 2013[2012] Kentucky Individual Tax Return and related schedules.

(18) Revenue Form 42A740-J, "Schedule J, Kentucky Farm Income Averaging", shall be completed by individuals and attached to Form 740 to compute tax liability by averaging farm income for taxable years beginning after December 31, 1997.

(19) Revenue Form 42A740-KNOL, "Schedule KNOL, 2013[2012] Kentucky Net Operating Loss Schedule", shall be used by individuals to compute and carry forward a net operating loss to subsequent years.

(20) Revenue Form 42A740-M, "Schedule M, 2013[2012] Kentucky Federal Adjusted Gross Income Modifications", shall be completed by individuals and attached to Form 740 in support of additions to and subtractions from federal adjusted gross income.

(21) Revenue Form 42A740-NP, "Form 740-NP, 2013[2012] Kentucky Individual Income Tax Return, Nonresident or Part-Year Resident", shall be completed by part-year or full-year nonresident individuals to report taxable income and income tax liability for taxable years beginning in 2013[2012], and shall be filed within three and one-half (3 1/2) months after the close of the taxable year.

(22) Revenue Form 42A740-NP-A, "Schedule A, Form 740-NP, 2013[2012] Kentucky Schedule A Itemized Deductions", shall be completed and attached to Form 42A740-NP by part-year or full-year nonresidents to support the itemized deductions claimed for 2013[2012].

(23) Revenue Form 42A740-NP-ME, "Schedule ME, Form 740-NP, 2013[2012] Moving Expense and Reimbursement", shall be completed and attached to Form 42A740-NP by part-year or full-year nonresidents to support moving expenses and reimbursement by employers for moving expenses for 2013[2012].

(24) Revenue Form 42A740-NP(I), "Instructions for 2013[2012] Kentucky Form 740-NP, Nonresident or Part-Year Resident Income Tax Return", shall be used by nonresident or part-year resident individuals to file the 2013[2012] Kentucky Form 740-NP and related schedules.

(25) Revenue Form 42A740-NP-R, "Form 740-NP-R, 2013[2012] Kentucky Income Tax Return Nonresident - Reciprocal State", shall be completed by resident individuals of reciprocal states to request a refund of Kentucky withholding for 2013[2012].

(26) Revenue Form 42A740-NP(P), "2013[2012] Kentucky Income Tax Return, Nonresident or Part-Year Resident", shall be a packet containing forms and instructions and shall be mailed to nonresident and part-year resident individuals for use in filing a Kentucky individual tax return for 2013[2012].

(27) Revenue Form 42A740(PKT), "2013[2012] Kentucky Individual Income Tax Forms", shall be a packet containing forms and instructions and shall be mailed to resident individuals for use in filing a Kentucky individual tax return for 2013[2012].

(28) Revenue Form 42A740-P, "Schedule P, 2013[2012] Kentucky Pension Income Exclusion", shall be completed by individuals and attached to Form 740 to compute the amount of allowable pension exclusion for 2013[2012].

(29) Revenue Form 42A740-UTC, "Schedule UTC, Unemployment Tax Credit", shall be completed by individuals and attached to Form 740 or Form 740-NP to provide the Office of Employment and Training Certificate Numbers in support of credit claimed for hiring an unemployed person.

(30) Revenue Form 42A740-X, "Form 740-X, Amended Kentucky Individual Income Tax Return", shall be completed by individuals and filed with the Department of Revenue to amend a previously filed tax return for 2005 or future years.

(31) Revenue Form 42A740-XP, "Form 740-XP, Amended Kentucky Individual Income Tax Return, 2004 and Prior Years", shall be completed by individuals and filed with the Department of Revenue to amend a previously filed tax return for 2004 or prior years.

(32) Revenue Form 42A740-S1, "Form 2210-K, 2013[2012] Underpayment of Estimated Tax by Individuals", shall be filed by individuals to request a waiver of estimated tax penalty or to compute and self assess an estimated tax penalty for a tax year beginning in 2013[2012].

(33) Revenue Form 42A740-S4, "2014[2013] Instructions for Filing Estimated Tax Vouchers", shall be used to compute the amount of estimated tax due for 2014[2013].

(34) Revenue Form 42A740-S18, "Form 8582-K, 2013[2012] Kentucky Passive Activity Loss Limitations", shall be completed by an individual taxpayer and attached to the individual tax return in support of an allowable passive loss deduction and carryover of a passive activity loss.

(35) Revenue Form 42A740-S21, "Form 4972-K, 2013[2012] Kentucky Tax on Lump-Sum Distributions", shall be completed by an individual taxpayer to compute tax liability on a lump sum

distribution and attached to the taxpayer's individual income tax return.

(36) Revenue Form 42A740-S22, "Form 8879-K, 2013[2012] Kentucky Individual Income Tax Declaration for Electronic Filing", shall be completed, signed by the individual taxpayer or taxpayers and maintained by the preparer or taxpayer in support of an electronically filed return.

(37) Revenue Form 42A740-S23, "Form 740-V, 2013[2012] Kentucky Electronic Payment Voucher", shall be used by the individual taxpayer or taxpayers for the payment of additional tax due on an electronically filed return and submitted to the Department of Revenue.

(38) Revenue Form 42A740-S24, "Form 8863-K, 2013[2012] Kentucky Education Tuition Tax Credit", shall be used by an individual taxpayer or taxpayers to claim a tuition tax credit on the taxpayer's individual Kentucky income tax return.

(39) Revenue Form 42A740-S25, "Form 8948-K, Preparer Explanation For Not Filing Electronically", shall be used by the preparer to indicate the reason the return is not being filed electronically.

(40) Revenue Form 42A741, "Form 741, 2013[2012] Kentucky Fiduciary Income Tax Return", shall be used by a fiduciary of an estate or trust to report income and tax liability of an estate or trust and be filed with the Department of Revenue within three (3) months and fifteen (15) days after the close of the taxable year.

(41) Revenue Form 42A741-D, "Schedule D, Form 741, 2013[2012] Kentucky Capital Gains and Losses", shall be completed and attached to Form 741 by a fiduciary to report income from capital gains and losses.

(42) Revenue Form 42A741(I), "Instructions - Form 741, Kentucky Fiduciary Income Tax Return", shall be the instruction guide provided by the Department of Revenue for completing the 2013[2012] Form 741.

(43) Revenue Form 42A741(K-1), "Schedule K-1, Form 741, 2013[2012] Kentucky Beneficiary's Share of Income, Deductions, Credits, etc.", shall be filed by the fiduciary with Form 741 to report each beneficiary's share of income, deductions, and credits.

(44) Revenue Form 42A765-GP, "Form 765-GP, 2013[2012] Kentucky General Partnership Income Return", shall be completed and filed with the Department of Revenue within three (3) months and fifteen (15) days after the close of the taxable year by a general partnership to report income, deductions, and credits of a general partnership for 2013[2012].

(45) Revenue Form 42A765-GP(I), "Instructions, 2013[2012] Kentucky General Partnership Income Return", shall be provided to assist the general partnership in completing a general partnership income return.

(46) Revenue Form 765-GP(K-1), "Schedule K-1, Form 765-GP, 2013[2012] Partner's Share of Income, Credits, Deductions, etc.", shall be filed by the general partnership with Form 765-GP to report each general partner's share of income, deductions, and credits.

(47) Revenue Form 42A765-GP(K), "Form 765-GP(K), Kentucky Schedule K for General Partnerships with Economic Development Project(s)", shall be used by a general partnership which has one (1) or more economic development projects to determine the total general partners' share of income, credits, deductions, etc., excluding the amount of each item of income, credit, deduction, etc., attributable to the projects.

(48) Revenue Form 42A801, "Form K-1, Kentucky Employer's Income Tax Withheld Worksheet", shall be used by employers to report wages and taxes withheld for the filing period.

(49) Revenue Form 42A801(D), "Form K-1, Amended Employer's Return of Income Tax Withheld", shall be used by employers to correct wages and taxes reported for the filing period.

(50) Revenue Form 42A801-E, "Form K-1E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", shall be used by employers who remit taxes withheld electronically to report wages and tax withheld for the filing period.

(51) "Form W-2, 2013[2012] Wage and Tax Statement", shall be used by an employer to report each of its employees' wages and Kentucky tax withheld for the calendar year 2013[2012].

(52) Revenue Form 42A803, "Form K-3, Kentucky Employer's

Income Tax Withheld Worksheet", shall be used by employers to report wages and tax withheld for the filing period and annually reconcile wages and taxes reported.

(53) Revenue Form 42A803(D), "Form K-3, Amended Employer's Return of Income Tax Withheld", shall be used by employers to amend wages and taxes reported for the filing period and the annual reconciled wages and taxes reported.

(54) Revenue Form 42A803-E, "Form K-3E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", shall be used by employers to report wages and tax withheld for the filing period and to annually reconcile wages and taxes reported.

(55) Revenue Form 42A804, "Form K-4, Kentucky Department of Revenue Employee's Withholding Exemption Certificate", shall be used by an employee to inform the employer of the number of exemptions claimed in order to determine the amount of Kentucky tax to withhold from wages each pay period.

(56) Revenue Form 42A804-A, "Form K-4A, Kentucky Department of Revenue Withholding Exemptions for Excess Itemized Deductions", shall be used by an employee to determine additional withholding exemptions.

(57) Revenue Form 42A804-E, "Form K-4E, Special Withholding Exemption Certificate", shall be used by employees to inform employers of special tax exempt status.

(58) Revenue Form 42A804-M, "Form K-4M, Nonresident Military Spouse Withholding Tax Exemption Certificate", shall be used by employees to inform employers of special tax exempt status as a nonresident military spouse.

(59) Revenue Form 42A806, "Transmitter Report for Filing Kentucky W2/K2, 1099 and W2-G Statements", shall be used by employers annually to submit Form W-2 Wage and Tax Statements.

(60) Revenue Form 42A807, "Form K-4FC, Fort Campbell Exemption Certificate", shall be completed by nonresident employees working at Fort Campbell, Kentucky, to inform employers of special tax exempt status.

(61) Revenue Form 42A808, "Authorization to Submit Employees Annual Wage and Tax Statements Via Kentucky Department of Revenue Web Site", shall be used by employers to request authorization to annually submit wage and tax statements via the Kentucky Department of Revenue Web site.

(62) Revenue Form 42A809, "Certificate of Nonresidence", shall be used by employees to inform employers of special tax exempt status as a result of being a resident of a reciprocal state.

(63) Revenue Form 42A810, "Nonresident's Affidavit - Kentucky Individual Income Tax", shall be used by individuals to submit a sworn statement concerning residency status.

(64) Revenue Form 42A811, "KREDA Annual Report", shall be completed by employers to report KREDA employee wage assessment fee information to the Department of Revenue.

(65) Revenue Form 42A812, "KIDA Annual Report", shall be completed by employers to report KIDA employee wage assessment fee information to the Department of Revenue.

(66) Revenue Form 42A813, "KJDA Annual Report", shall be completed by employers to report KJDA employee wage assessment fee information to the Department of Revenue.

(67) Revenue Form 42A814, "KIRA Annual Report", shall be completed by employers to report KIRA employee wage assessment fee information to the Department of Revenue.

(68) Revenue Form 42A815, "Withholding Tax Refund Application", shall be completed by employers to request a refund of withholding tax paid.

(69) Revenue Form 42A816, "KEOZ Annual Report", shall be completed by employers to report KEOZ employee wage assessment fee information to the Department of Revenue.

(70) Revenue Form 42A817, "KJRA Annual Report", shall be completed by employers to report KJRA employee wage assessment fee information to the Department of Revenue.

(71) Revenue Form 42A818, "KBI Annual Report", shall be completed by employers to report KBI employee wage assessment fee information to the Department of Revenue.

(72) Revenue Form 42D003, "2013[2012] Kentucky Wage and Tax Statements (W-2/K-2) Order Form", shall be used by

employers to order wage and tax statements.

Section 3. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Corporation income taxes - referenced material:

1. Revenue Form 41A720, "Form 720, 2013[2012] Kentucky Corporation Income Tax and LLET Return", 2013[2012];

2. Revenue Form 41A720A, "Schedule A, Apportionment and Allocation (For corporations and pass-through entities taxable both within and without Kentucky)", October 2013[2012];

3. Revenue Form 41A720A-C, "Schedule A-C, Apportionment and Allocation - Continuation Sheet", October 2013[2012];

4. Revenue Form 41A720A-N, "Schedule A-N, Apportionment Factor Schedule", October 2013[2012];

5. Revenue Form 41A720BIO, "Schedule BIO, Application and Credit Certificate of Income Tax/LLET Credit Biodiesel", October 2013[2012];

6. Revenue Form 41A720CC, "Schedule CC, Coal Conversion Tax Credit", October 2013[2012];

7. Revenue Form 41A720-CCI, "Schedule CCI, Application and Credit Certificate of Clean Coal Incentive Tax Credit", October 2013[2012];

8. Revenue Form 41A720CELL, "Schedule CELL, Application and Credit Certificate of Income Tax/LLET Credit Cellulosic Ethanol", October 2013[2012];

9. Revenue Form 41A720-CI, "Schedule CI, Application for Coal Incentive Tax Credit", October 2013[2012];

10. Revenue Form 41A720COGS, "Schedule COGS, Limited Liability Entity Tax Cost of Goods Sold", October 2013;

11. Revenue Form 41A720CR, "Schedule CR, Pro Forma Federal Consolidated Return Schedule", October 2013[2012];

12.[14-] Revenue Form 41A720CR-C, "Schedule CR-C, Pro Forma Federal Consolidated Return Schedule Continuation Sheet", October 2013[2012];

13.[12-] Revenue Form 41A720ES, "Form 720-ES Kentucky, 2014[2013] Corporation Income/Limited Liability Entity Tax Estimated Tax Voucher", June 2013[2012];

14.[13-] Revenue Form 41A720ETH, "Schedule ETH, Application and Credit Certificate of Income Tax/LLET Credit Ethanol", October 2013[2012]; [14- Revenue Form 41A720EZC, "Schedule EZC, Enterprise Zone Tax Credit", October 2012;]

15. Revenue Form 41A720FD, "Schedule FD, Food Donation Tax Credit", October 2013;

16. Revenue Form 41A720HH, "Schedule HH, Kentucky Housing for Homeless Families Deduction", October 2013[2012];

17.[16-] Revenue Form 41A720(I), "Instructions, 2013[2012] Kentucky Corporation Income Tax and LLET Return", November 2013[2012];

18.[17-] Revenue Form 41A720KCR, "Schedule KCR, Kentucky Consolidated Return Schedule", October 2013[2012];

19.[18-] Revenue Form 41A720KCR-C, "Schedule KCR-C, Kentucky Consolidated Return Schedule - Continuation Sheet", October 2013[2012];

20.[19-] Revenue Form 41A720KESA, "Schedule KESA, Tax Credit Computation Schedule (For a KESA Project of a Corporation)", October 2013[2012];

21.[20-] Revenue Form 41A720KESA-SP, "Schedule KESA-SP, Tax Credit Computation Schedule (For a KESA Project of a Pass-Through Entity)", October 2013[2012];

22.[21-] Revenue Form 41A720KESA-T, "Schedule KESA-T, Tracking Schedule for a KESA Project", October 2013[2012];

23.[22-] Revenue Form 41A720LLET, "Schedule LLET, Limited Liability Entity Tax", October 2013[2012];

24.[23-] Revenue Form 41A720LLET-C, "Schedule LLET-C, Limited Liability Entity Tax - Continuation Sheet", October 2013[2012];

25.[24-] Revenue Form 41A720LLET(K), "Schedule LLET(K), Limited Liability Entity Tax (For a Limited Liability Pass-through Entity with Economic Development Project(s))", October 2013[2012];

26.[25-] Revenue Form 41A720LLET(K)-C, "Schedule LLET(K)-C, Limited Liability Entity Tax - Continuation Sheet", October 2013[2012];

27.[26-] Revenue Form 41A720NOL, "Schedule NOL, Net Operating Loss Schedule", October 2013[2012];

28.[27-] Revenue Form 41A720NOL-CF, "Schedule NOL-CF, Kentucky NOL Carry forward Schedule", October 2013[2012];

29.[28-] Revenue Form 41A720-O, "Schedule O-720, Other Additions and Subtractions To/From Federal Taxable Income", December 2013[2012];

30.[29-] Revenue Form 41A720QR, "Schedule QR, Qualified Research Facility Tax Credit", October 2013[2012];

31.[30-] Revenue Form 41A720RC, "Schedule RC, Application for Income Tax/LLET Credit for Recycling and/or Composting Equipment or Major Recycling Project", October 2013[2012];

32.[31-] Revenue Form 41A720RC-C, "Schedule RC-C, Schedule RC - Part I Continuation", October 2013[2012];

33.[32-] Revenue Form 41A720RC(I), "Instructions For Schedule RC", October 2013[2012];

34.[33-] Revenue Form 41A720RC-R, "Schedule RC-R, Recycling or Composting Equipment Tax Credit Recapture", October 2013[2012];

35.[34-] Revenue Form 41A720RPC, "Schedule RPC, Related Party Costs Disclosure Statement", June 2013[2012];

36.[35-] Revenue Form 41A720RR-E, "Schedule RR-E, Application and Credit Certificate of Income Tax/LLET Credit Railroad Expansion", October 2013[2012];

37.[36-] Revenue Form 41A720RR-I, "Schedule RR-I, Railroad Maintenance and Improvement Tax Credit", October 2013[2012];

38.[37-] Revenue Form 41A720S, "Form 720S, 2013[2012] Kentucky S Corporation Income Tax and LLET Return", 2013[2012];

39.[38-] Revenue Form 41A720S(I), "Instructions, 2013[2012] Kentucky S Corporation Income Tax and LLET Return", November 2013[2012];

40.[39-] Revenue Form 41A720S(K), "Form 720S(K), Kentucky Schedule K for S Corporations With Economic Development Project(s)", October 2013[2012];

41.[40-] Revenue Form 41A720S(K-1), "Schedule K-1 (Form 720S), 2013[2012] Shareholder's Share of Income, Credits, Deductions, Etc.", 2013[2012];

42.[41-] Revenue Form 41A720S-O, "Schedule O-PTE, Other Additions and Subtractions To/From Federal Ordinary Income", November 2013[2012];

43.[42-] Revenue Form 41A720SL, "Application for Six-Month Extension of Time to File Kentucky Corporation or Limited Liability Pass-Through Entity Return", June 2013[2012];

44.[43-] Revenue Form 41A720TCS, "Schedule TCS, Tax Credit Summary Schedule", October 2013[2012];

45.[44-] Revenue Form 41A720VERB, "Schedule VERB, Voluntary Environmental Remediation Tax Credit", October 2013[2012];

46.[45-] Revenue Form 41A720-S1, "Form 720X, Amended Kentucky Corporation Income Tax and Corporation License Tax Return", October 2011;

47.[46-] Revenue Form 41A720-S2, "Form 720-AMENDED, Amended Kentucky Corporation Income Tax Return", October 2011;

48.[47-] Revenue Form 41A720-S3, "Form 720-AMENDED (2007-2008), Amended Kentucky Corporation Income Tax and LLET Return", October 2011;

49.[48-] Revenue Form 41A720-S4, "Form 851-K, Kentucky Affiliations and Payment Schedule", October 2013[2012];

50.[49-] Revenue Form 41A720-S6, "Form 2220-K, Underpayment and Late Payment of Estimated Income Tax and LLET", October 2013[2012];

51.[50-] Revenue Form 41A720-S7, "Form 5695-K, Kentucky Energy Efficiency Products Tax Credit", October 2013[2012];

52. Revenue Form 41A720-S8, "Form 8879(C) – K, Kentucky Corporation or Pass-Through Entity Tax Return Declaration for Electronic Filing", October 2013;

53.[51-] Revenue Form 41A720-S9, "Schedule 8903-K, Kentucky Domestic Production Activities Deduction", October 2013[2012];

54.[52-] Revenue Form 41A720-S11, "Form 8908-K, Kentucky ENERGY STAR (Homes and Manufactured Homes) Tax Credit",

October 2013[2012];

55. Revenue Form 41A720-S12, "720-V, Electronic Filing Payment Voucher", October 2013;

56.[53-] Revenue Form 41A720-S16, "Schedule KREDA, Tax Credit Computation Schedule (For a KREDA Project of a Corporation)", October 2013[2012];

57.[54-] Revenue Form 41A720-S17, "Schedule KREDA-T, Tracking Schedule for a KREDA Project", October 2013[2012];

58.[55-] Revenue Form 41A720-S18, "Schedule KREDA-SP, Tax Computation Schedule (For a KREDA Project of a Pass-Through Entity)", October 2013[2012];

59.[56-] Revenue Form 41A720-S20, "Schedule KIDA, Tax Credit Computation Schedule (For a KIDA Project of a Corporation)", October 2013[2012];

60.[57-] Revenue Form 41A720-S21, "Schedule KIDA-T, Tracking Schedule for a KIDA Project" October 2013[2012];

61.[58-] Revenue Form 41A720-S22, "Schedule KIDA-SP, Tax Computation Schedule (For a KIDA Project of a Pass-Through Entity)", October 2013[2012];

62.[59-] Revenue Form 41A720-S24, "Schedule KIRA, Tax Credit Computation Schedule (For a KIRA Project of a Corporation)", October 2013[2012];

63.[60-] Revenue Form 41A720-S25, "Schedule KIRA-T, Tracking Schedule for a KIRA Project", October 2013[2012];

64.[61-] Revenue Form 41A720-S26, "Schedule KIRA-SP, Tax Computation Schedule (For a KIRA Project of a Pass-Through Entity)", October 2013[2012];

65.[62-] Revenue Form 41A720-S27, "Schedule KJDA, Tax Credit Computation Schedule (For a KJDA Project of a Corporation)", October 2013[2012];

66.[63-] Revenue Form 41A720-S28, "Schedule KJDA-T, Tracking Schedule for a KJDA Project", October 2013[2012];

67.[64-] Revenue Form 41A720-S29, "Schedule KJDA-SP, Tax Computation Schedule (For a KJDA Project of a Pass-Through Entity)", October 2013[2012];

68.[65-] Revenue Form 41A720-S35, "Schedule KRA, Tax Credit Computation Schedule (For a KRA Project of a Corporation)", October 2013[2012];

69.[66-] Revenue Form 41A720-S36, "Schedule KRA-SP, Tax Computation Schedule (For a KRA Project of a Pass-Through Entity)", October 2013[2012];

70.[67-] Revenue Form 41A720-S37, "Schedule KRA-T, Tracking Schedule for a KRA Project", October 2013[2012];

71.[68-] Revenue Form 41A720-S40, "Schedule KEOZ, Tax Credit Computation Schedule (For a KEOZ Project of a Corporation)", October 2013[2012];

72.[69-] Revenue Form 41A720-S41, "Schedule KEOZ-SP, Tax Computation Schedule (For a KEOZ Project of a Pass-Through Entity)", October 2013[2012];

73.[70-] Revenue Form 41A720-S42, "Schedule KEOZ-T, Tracking Schedule for a KEOZ Project", October 2013[2012];

74.[71-] Revenue Form 41A720-S45, "Schedule KJRA, Tax Credit Computation Schedule (For a KJRA Project of a Corporation)", October 2013[2012];

75.[72-] Revenue Form 41A720-S46, "Schedule KJRA-T, Tracking Schedule for a KJRA Project", October 2013[2012];

76.[73-] Revenue Form 41A720-S47, "Schedule KJRA-SP, Tax Computation Schedule (For a KJRA Project of a Pass-Through Entity)", October 2013[2012];

77.[74-] Revenue Form 41A720-S50, "Schedule IEIA, Tax Credit Computation Schedule (For an IEIA Project of a Corporation)", October 2013[2012];

78.[75-] Revenue Form 41A720-S51, "Schedule IEIA-T, Tracking Schedule for an IEIA Project", October 2013[2012];

79.[76-] Revenue Form 41A720-S52, "Schedule IEIA-SP, Tax Computation Schedule (For an IEIA Project of a Pass-Through Entity)", October 2013[2012];

80.[77-] Revenue Form 41A720-S53, "Schedule KBI, Tax Credit Computation Schedule (For a KBI Project of a Corporation)", October 2013[2012];

81.[78-] Revenue Form 41A720-S54, "Schedule KBI-SP, Tax Computation Schedule (For a KBI Project of a Pass-Through Entity)", October 2013[2012];

82.[79-] Revenue Form 41A720-S55, "Schedule KBI-T, Tracking Schedule for a KBI Project", October 2013[2012];

83. Revenue Form 41A720-S56, "Schedule FON, Tax Credit Computation Schedule (For a FON project of a corporation)", October 2013;

84. Revenue Form 41A720-S57, "Schedule FON-SP, Tax Computation Schedule (For a FON project of a Pass-Through Entity)", October 2013;

85. Revenue Form 41A720-S58, "Schedule FON-T, Tracking Schedule for a FON project", October 2013;

86.[80-] Revenue Form 41A720-S80, "Form 8874(K), Application for Certification of Qualified Equity Investments Eligible for Kentucky New Markets Development Program Tax Credit", June 2010;

87.[81-] Revenue Form 41A720-S81, "Form 8874(K)-A, Notice of Kentucky New Markets Development Program Tax Credit and Certification", June 2013[2012];

88.[82-] Revenue Form 41A720-S82, "Form 8874(K)-B, Notice of Kentucky New Markets Development Program Tax Credit Recapture", June 2013[2012];

89.[83-] Revenue Form 41A725, "Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", 2013[2012];

90.[84-] Revenue Form 41A725CP, "Schedule CP, Form 725, 2013[2012] Kentucky Single Member LLC Individually Owned Composite Return Schedule", 2013[2012];

91.[85-] Revenue Form 41A725(I), "Instructions, 2013[2012] Kentucky Single Member LLC Individually Owned LLET Return", October 2013[2012];

92.[86-] Revenue Form 41A750, "Form 750, Business Development Corporation Tax Return", September 2013[2012];

93.[87-] Revenue Form 41A765, "Form 765, 2013[2012] Kentucky Partnership Income and LLET Return", 2013[2012];

94.[88-] Revenue Form 41A765(I), "Instructions, 2013[2012] Kentucky Partnership Income and LLET Return", November 2013[2012];

95.[89-] Revenue Form 41A765(K), "Form 765(K), Kentucky Schedule K For Partnerships With Economic Development Project(s)", October 2013[2012];

96.[90-] Revenue Form 41A765(K-1), "Schedule K-1 (Form 765), 2013[2012] Partner's Share of Income, Credits, Deductions, Etc.", 2013[2012];

97.[91-] Revenue Form 41A800, "Corporation and Pass-through Entity Nexus Questionnaire", December 2013[2011]; and

98.[92-] Revenue Form 41A802, "Corporation and Pass-through Entity Related Party Expense Questionnaire", June 2013[October 2012]; and

(b) Individual income and withholding taxes - referenced material:

1. Revenue Form 12A200, "Kentucky Individual Income Tax Installment Agreement Request", November 2013[2012];

2. Revenue Form 40A100, "Application for Refund of Income Taxes", October 2013[2012];

3. Revenue Form 40A102, "2013[2012] Application for Extension of Time to File Individual, General Partnership and Fiduciary Income Tax Returns for Kentucky", November 2013[2012];

4. Revenue Form 40A103, "Application for New Home Tax Credit", June 2010;

5. Revenue Form 40A200, "Form PTE-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income", October 2013[2012];

6. Revenue Form 40A201, "Form 740NP-WH, Kentucky Nonresident Income Tax Withholding on Distributive Share Income Report and Composite Income Tax Return", October 2013[2012];

7. Revenue Form 40A201ES, "Form 740NP-WH-ES, Instructions – 2014[2013] Pass-Through Entity Nonresident Distributive Share Withholding Report and Composite Income Tax Return Voucher", October 2013[2012];

8. Revenue Form 40A201NP-WH-SL, "Form 740NP-WH-SL, Application for Six-Month Extension of Time to File Form 740NP-WH", October 2013[2012];

9. Revenue Form 40A201-WHP, "Form 740NP-WH-P,

Underpayment and Late Payment of Estimated Tax on Form 740NP-WH", October 2013[2012];

10. Revenue Form 40A727, "Kentucky Income Tax Forms Requisition", October 2013[2012];

11. Revenue Form 42A003, "Withholding Kentucky Income Tax Instructions for Employers", August 2011;

12. Revenue Form 42A003(T), "2014[2013] Withholding Tax Tables Computer Formula", September 2013[2012];

13. Revenue Form 42A740, "Form 740, 2013[2012] Kentucky Individual Income Tax Return, Full-Year Residents Only", 2013[2012];

14. Revenue Form 42A740-A, "Schedule A, Form 740, 2013[2012] Kentucky Itemized Deductions", 2013[2012];

15. Revenue Form 42A740ES, "Form 740-ES, 2014[2013] Individual Income Tax Kentucky Estimated Tax Voucher", September 2013[June 2012];

16. Revenue Form 42A740-EZ, "Form 740-EZ, 2013[2012] Kentucky Individual Income Tax Return for Single Persons with No Dependents", 2013[2012];

17. Revenue Form 42A740(I), "2013[2012] Kentucky Individual Income Tax Instructions for Forms 740 and 740-EZ", October 2013[2012];

18. Revenue Form 42A740-J, "Schedule J, Kentucky Farm Income Averaging", October 2013[2012];

19. Revenue Form 42A740-KNOL, "Schedule KNOL, 2013[2012] Kentucky Net Operating Loss Schedule", 2013[2012];

20. Revenue Form 42A740-M, "Schedule M, 2013[2012] Kentucky Federal Adjusted Gross Income Modifications", 2013[2012];

21. Revenue Form 42A740-NP, "Form 740-NP, 2013[2012] Kentucky Individual Income Tax Return, Nonresident or Part-Year Resident", 2013[2012];

22. Revenue Form 42A740-NP-A, "Schedule A, Form 740-NP, 2013[2012] Kentucky Schedule A Itemized Deductions", 2013[2012];

23. Revenue Form 42A740-NP-ME, "Schedule ME, Form 740-NP, 2013[2012] Moving Expense and Reimbursement", 2013[2012];

24. Revenue Form 42A740-NP(I), "Instructions for 2013[2012] Kentucky Form 740-NP, Nonresident or Part-Year Resident Income Tax Return", October 2013[2012];

25. Revenue Form 42A740-NP-R, "Form 740-NP-R, 2013[2012] Kentucky Income Tax Return Nonresident - Reciprocal State", 2013[2012];

26. Revenue Form 42A740-NP(P), "2013[2012] Kentucky Income Tax Return Nonresident or Part-Year Resident", October 2013[2012];

27. Revenue Form 42A740(PKT), "2013[2012] Kentucky Individual Income Tax Forms", October 2013[2012];

28. Revenue Form 42A740-P, "Schedule P, 2013[2012] Kentucky Pension Income Exclusion", 2013[2012];

29. Revenue Form 42A740-UTC, "Schedule UTC, Unemployment Tax Credit", October 2013[2012];

30. Revenue Form 42A740-X, "Form 740-X, Amended Kentucky Individual Income Tax Return", November 2013[2012];

31. Revenue Form 42A740-XP, "Form 740-XP, Amended Kentucky Individual Income Tax Return, 2004 and Prior Years", November 2008;

32. Revenue Form 42A740-S1, "Form 2210-K, 2013[2012] Underpayment of Estimated Tax by Individuals", 2013[2012];

33. Revenue Form 42A740-S4, "2014[2013] Instructions for Filing Estimated Tax Vouchers", October 2013[2012];

34. Revenue Form 42A740-S18, "Form 8582-K, 2013[2012] Kentucky Passive Activity Loss Limitations", 2013[2012];

35. Revenue Form 42A740-S21, "Form 4972-K, 2013[2012] Kentucky Tax on Lump-Sum Distributions", 2013[2012];

36. Revenue Form 42A740-S22, "Form 8879-K, 2013[2012] Kentucky Individual Income Tax Declaration for Electronic Filing", 2013[2012];

37. Revenue Form 42A740-S23, "Form 740-V, 2013[2012] Kentucky Electronic Payment Voucher", November 2013[2012];

38. Revenue Form 42A740-S24, "Form 8863-K, 2013[2012] Kentucky Education Tuition Tax Credit", 2013[2012];

39. Revenue Form 42A740-S25, "Form 8948-K, Preparer Explanation For Not Filing Electronically", October 2013[2012];

40. Revenue Form 42A741, "Form 741, 2013[2012] Kentucky Fiduciary Income Tax Return", 2013[2012];

41. Revenue Form 42A741-D, "Schedule D, Form 741, 2013[2012] Kentucky Capital Gains and Losses", 2013[2012];

42. Revenue Form 42A741(I), "Instructions - Form 741, Kentucky Fiduciary Income Tax Return", October 2013[2012];

43. Revenue Form 42A741(K-1), "Schedule K-1, Form 741, 2013[2012] Kentucky Beneficiary's Share of Income, Deductions, Credits, etc.", 2013[2012];

44. Revenue Form 42A765-GP, "Form 765-GP, 2013[2012] Kentucky General Partnership Income Return", 2013[2012];

45. Revenue Form 42A765-GP(I), "Instructions, 2013[2012] Kentucky General Partnership Income Return", November 2013[2012];

46. Revenue Form 765-GP(K-1), "Schedule K-1, Form 765-GP, 2013[2012] Partner's Share of Income, Credits, Deductions, etc.", 2013[2012];

47. Revenue Form 42A765-GP(K), "Form 765-GP(K), Kentucky Schedule K for General Partnerships with Economic Development Project(s)", October 2013[2012];

48. Revenue Form 42A801, "Form K-1, Kentucky Employer's Income Tax Withheld Worksheet", March 2007;

49. Revenue Form 42A801(D), "Form K-1, Amended Employer's Return of Income Tax Withheld", April 2008;

50. Revenue Form 42A801-E, "Form K-1E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", March 2007;

51. "Form W-2, 2013[2012] Wage and Tax Statement", 2013[2012];

52. Revenue Form 42A803, "Form K-3, Kentucky Employer's Income Tax Withheld Worksheet", March 2007;

53. Revenue Form 42A803(D), "Form K-3, Amended Employer's Return of Income Tax Withheld", April 2008;

54. Revenue Form 42A803-E, "Form K-3E, Kentucky Employer's Income Tax Withheld Worksheet - Electronic Funds Transfer", March 2007;

55. Revenue Form 42A804, "Form K-4, Kentucky Department of Revenue Employee's Withholding Exemption Certificate", November 2013[2010];

56. Revenue Form 42A804-A, "Form K-4A, Kentucky Department of Revenue Withholding Exemptions for Excess Itemized Deductions", April 2008;

57. Revenue Form 42A804-E, "Form K-4E, Special Withholding Exemption Certificate", May 2013[March 2012];

58. Revenue Form 42A804-M, "Form K-4M, Nonresident Military Spouse Withholding Tax Exemption Certificate", November 2010;

59. Revenue Form 42A806, "Transmitter Report for Filing Kentucky W2/K2, 1099 and W2-G Statements", July 2013[October 2011];

60. Revenue Form 42A807, "Form K-4FC, Fort Campbell Exemption Certificate", August 2006;

61. Revenue Form 42A808, "Authorization to Submit Employees Annual Wage and Tax Statements Via Kentucky Department of Revenue Web Site", March 2006;

62. Revenue Form 42A809, "Certificate of Nonresidence", March 2007;

63. Revenue Form 42A810, "Nonresident's Affidavit - Kentucky Individual Income Tax", April 1989;

64. Revenue Form 42A811, "KREDA Annual Report", December 2007;

65. Revenue Form 42A812, "KIDA Annual Report", December 2007;

66. Revenue Form 42A813, "KJDA Annual Report", December 2007;

67. Revenue Form 42A814, "KIRA Annual Report", December 2007;

68. Revenue Form 42A815, "Withholding Tax Refund Application", August 2006;

69. Revenue Form 42A816, "KEOZ Annual Report", December 2007;

70. Revenue Form 42A817, "KJRA Annual Report", October 2010;

71. Revenue Form 42A818, "KBI Annual Report", October 2010; and

72. Revenue Form 42D003, "2013[2012] Kentucky Wage and Tax Statements (W-2/K-2) Order Form", August 2013[July 2012].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Revenue, 501 High Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 5 p.m.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: December 23, 2013

FILED WITH LRC: December 27, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 from 10:00 a.m. to 12:00 p.m., in Room 381, Capitol Annex Building, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 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 February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed amended administrative regulation to the contact person.

CONTACT PERSON: Lisa Swiger, Staff Assistant, Department of Revenue, Finance and Administration Cabinet, 501 High Street, Frankfort, Kentucky 40601, phone (502) 564-9826, fax (502) 564-2541.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lisa Swiger

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation prescribes the forms to be used when reporting and paying corporation income tax, limited liability entity tax, individual income tax for tax years beginning in 2013; withholding taxes for calendar year 2013; and installments of estimated tax for tax years beginning in 2014.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order to provide taxpayers necessary tax forms for reporting and paying their corporation income tax, limited liability entity tax, individual income tax for tax years beginning in 2013; withholding taxes for calendar year 2013; and installments of estimated tax for tax years beginning in 2014.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of any revenue law by the promulgation of an administrative regulation pursuant to KRS Chapter 13A incorporating forms by reference.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation prescribes forms to be used by taxpayers to report and pay corporation taxes, limited liability entity taxes, individual income taxes, and withholding taxes to the Commonwealth of Kentucky pursuant to KRS Chapter 141.

(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 contains income and limited liability entity tax forms to be used for tax years beginning in 2013, and estimated tax forms to be used for tax years beginning in 2014.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to update tax forms to the current tax laws in effect for years beginning in 2013.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 131.130(3) authorizes the Department of Revenue to prescribe tax forms necessary for the administration of the tax laws.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will provide taxpayers with the necessary tax forms to file and pay income taxes, limited liability entity taxes, and individual withholding taxes for tax years beginning in 2013.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All individual, pass-through entity and corporate tax filers are affected by this 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: Individual, pass-through entity, and corporate tax filers will use the forms contained in this administrative regulation to report, pay, and withhold taxes due pursuant to KRS Chapter 141 for tax years beginning in 2013.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The cost of filing tax returns contained in this administrative regulation with the Commonwealth of Kentucky should be comparable to filing tax returns with surrounding states.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The forms contained in this administrative regulation should simplify and expedite the reporting and paying of taxes required by KRS Chapter 141.

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

(a) Initially: The cost of printing and designing the forms.

(b) On a continuing basis: Forms are updated each year.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Funds will be provided by the Department of Revenue.

(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 additional funding will be required 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 does not establish any fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied as the forms included in this administrative regulation apply to all taxpayers taxed pursuant to KRS Chapter 141.

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? Finance and Administration Cabinet, Department of Revenue.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS Chapter 131.130(3).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. This administrative regulation will not increase revenues or expenses for the Commonwealth, but will expedite the collection of taxes provided by KRS Chapter 141.

(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 collected as a result of this 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? None.

(c) How much will it cost to administer this program for the first year? A very small increase in expenditures will occur in the administrative regulation process that will be absorbed by the department operating budget.

(d) How much will it cost to administer this program for subsequent years? No costs 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 Board of Licensure for Long Term Care Administrators (Amendment)

201 KAR 6:020. Other requirements for licensure.

RELATES TO: KRS 216A.070(1)(a), 216A.080(1)(d), (e)
STATUTORY AUTHORITY: KRS 216A.070(3),

216A.080(1)(d), (e)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216A.070 requires the Kentucky Board of Licensure for Long-Term Care Administrators to promulgate administrative regulations to develop, impose, and enforce standards which shall be met by an individual in order to receive a license. KRS 216A.080(1)(d) and (e) authorize the board to promulgate administrative regulations to establish examination requirements and other requirements to be met if the requirements are uniform and applied to each applicant for a license. KRS 216A.080(1)(d) requires an applicant to pass an examination approved by the board. This administrative regulation establishes requirements for licensure and sets limits on the taking of the examination.

Section 1. An applicant for a license as a long-term care administrator shall, in addition to meeting all of the requirements provided by KRS 216A.080(1):

(1) Have satisfactorily completed a course of study for, and have been awarded a baccalaureate degree from, an accredited college or university accredited by an agency recognized by the United States Department of Education;

(2)(a) Pass the written examination administered and verified by the National Association of Long-Term Care Administrator Boards; and

(b) Submit to the Board of Licensure for Long-Term Care Administrators documentation of a passing score, as defined by the National Association of Long-Term Care Administrator Boards.

1. This score shall not be less than seventy-five (75) percent of the scaled score.

2. The examination shall be passed within:

a. Two (2) years before filing an application for licensure or reinstatement; or

b. One (1) year~~Six (6) months~~ after filing an application for licensure or reinstatement; and

(3)(a) Except as provided in paragraph (b) and (c) of this subsection, have six (6) months of continuous management experience, or, if part-time, not less than 1,000 hours within a twenty-four (24) month period, with that experience to be completed in a long-term care facility. This experience shall be completed no more than two (2) years in advance of making application or within one (1) year after the filing of the~~two (2) years of the date of~~ application. The management experience shall include evidence of responsibility for:

1. Personnel management;

2. Budget preparation;

3. Fiscal management;

4. Public relations; and

5. Regulatory compliance and quality improvement.

(b) An internship, that is at least 1,000 hours in length, which is a part of a degree in long-term care administration or a related field, shall satisfy the experience requirement established in this subsection.

(c) A bachelor's or master's degree from an academic program accredited by the National Association of Long-Term Care Administrator Boards at the time of the applicant's graduation and which was awarded within two (2) years of the date of the application shall satisfy the experience requirement established in this subsection.

Section 2. (1) The examination for licensure established by KRS 216A.080(1)(e) shall be the examination prepared by the National Association of Long-Term Care Administrator Boards.

(2) An applicant shall not be permitted to sit for the examination more than four (4) times within twelve (12) months.

Section 3. Any application not completed within one (1) year[six (6) months] of the date of application[having been approved to take the exam] shall be mandatorily withdrawn as incomplete.

Section 4. A licensee shall provide the board with written notification within thirty (30) days of the occurrence of any of the following:

- (1) Change of home address;
- (2) Change of employer;
- (3) Conviction of a felony or misdemeanor;

(a) A licensee providing notice of a conviction shall provide a copy of the judgment in the case.

(b) A plea of nolo contendere or an alford plea shall not absolve the licensee of an obligation to report a conviction; or

(4) Immediate Jeopardy or Substandard Level of Care notice received from the Cabinet for Health and Family Services by the long-term care facility at which the licensee serves as the administrator of record. A licensee providing notice of a citation shall provide a copy of the inspection report and submitted plan of correction.

Section 5. An applicant for licensure shall complete and submit an Application for Licensure.

Section 6. Incorporation by Reference. (1) "Application for Licensure", January 2014[October 2013], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Licensure for Long-Term Care Administrators, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

GREG WELLS, Board Chair

APPROVED BY AGENCY: January 2, 2014

FILED WITH LRC: January 9, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 at 8:30 a.m. (EST) at 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled.

This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 p.m. on February 28, 2014. 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: Jennifer Hutcherson, Board Administrator, Board of Licensure for Long Term Care Administrators, PO Box 1360, Frankfort, Kentucky 40602, phone 502-564-3296.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Michael West

(1) Provide a brief summary of

(a) What this administrative regulation does: This regulation establishes other requirements for licensure as a long term care administrator.

(b) The necessity of this administrative regulation: This regulation is necessary to implement the provisions of KRS 216A.070(1)(a).

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity KRS 216A.070(3).

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will help the public in understanding the requirements for obtaining a license as a long term care administrator.

(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 edits the forms used for the administration of this regulation. It also changes time limits to correct internal inconsistencies mistakenly made during a previous revision.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure the requirements for licensure are understood per the forms. It is also necessary to change time limits to correct internal inconsistencies mistakenly made during a previous revision.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation is in conformity as the authorizing statute that gives the board the ability to promulgate regulations generally and to utilize forms to fulfill the process of those regulations.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation will assist the board by making the process of the board more easily understandable.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately 800 individuals are licensed by the board. This regulation primarily relates to future unidentified applicants.

(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 will need to be taken as the regulation relates to new applicants only.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): None.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will more readily understand the process they are to complete.

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

(a) Initially: No new costs will be incurred by the changes.

(b) On a continuing basis: No new costs will be incurred by the changes.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The board's operations are funded by fees paid by licensees.

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

will be required to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation does not establish any new fees. Nor does it increase any existing fees.

(9) TIERING: Is tiering applied? Tiering is not applied to this regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Licensure for Long Term Care Administrators.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 216A.070(3).

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(a) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None

(c) How much will it cost to administer this program for the first year? None

(d) How much will it cost to administer this program for subsequent years? None

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET

Board of Licensure for Long Term Care Administrators (Amendment)

201 KAR 6:040. Renewal, reinstatement, and reactivation of license.

RELATES TO: KRS 36.450, 216A.080, 216A.090

STATUTORY AUTHORITY: KRS 216A.070(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216A.070(3) authorizes the Board of Licensure for Long-term Care Administrators to promulgate administrative regulations necessary for the proper performance of its duties. KRS 216A.090 requires the holder of a license to renew that license biennially. This administrative regulation establishes the requirements for renewal, late renewal, inactive licensure, and reinstatement of a license.

Section 1. (1) A license shall be renewed every two (2) years from date of issue or from date of last renewal. To apply for renewal, a licensee shall:

(a) Submit a completed Renewal Form to the board; and

(b) Pay to the board the appropriate renewal fee established in 201 KAR 6:060 for the renewal of a license.

(2) A sixty (60) day grace period shall be allowed after the renewal date, during which time a licensee may continue to practice and may renew the license upon payment of the late renewal fee established in 201 KAR 6:060.

(a) Except as provided by KRS 36.450, a license not renewed by the end of the sixty (60) day grace period shall terminate based on the failure of the licensee to renew in a timely manner.

(b) Upon termination, the licensee shall not practice in the Commonwealth.

(3) A license shall be deemed inactive if:

(a) The board receives a written request seeking inactive status from the licensee;

(b) A licensee pays to the board the inactive licensee fee established in 201 KAR 6:060 for an inactive license;

(c) The grace period established in subsection (2) of this section has not expired; and

(d) The license is in good standing when the inactive status request is received.

(4)(a) After the sixty (60) day grace period, in order to apply for reinstatement, an individual with a terminated license shall submit a completed [Reinstatement] Application for Licensure and pay the reinstatement fee established in 201 KAR 6:060.

(b) A person who applies for reinstatement after expiration of a license shall not be required to meet current licensure requirements, except those established in 201 KAR 6:070, Section 10, if reinstatement application is made within two (2) years from the date of expiration.

(5)(a) In order to apply for reactivation, an individual with an inactive license shall submit a completed Application for Licensure [Inactive Renewal and Reactivation Form] accompanied by the reactivation fee established in 201 KAR 6:070.

(b) An individual who has continuously maintained inactive status and who makes application to return to active status shall not be required to meet current licensure requirements except those established by 201 KAR 6:070, Section 10.

(6) A licensee who fails to reinstate a license within two (2) years after its termination shall not have it renewed, restored, reissued, or reinstated. A person may apply for and obtain a new license by meeting the current requirements for licensure established in KRS 216A.080 and 201 KAR Chapter 6.

(7) A suspended license shall be subject to expiration and termination and shall be renewed as provided in this administrative regulation. Renewal shall not entitle the licensee to engage in the practice until the suspension has ended, or is otherwise removed by the board and the right to practice is restored by the board.

(8) A revoked license shall be subject to expiration or termination and shall not be renewed. If it is reinstated, the licensee shall pay the reinstatement fee as set forth in subsection (2) of this section and the renewal fee as set forth in subsection (1) of this section.

(9) A licensee applying for renewal, late renewal, or reinstatement of licensure shall show evidence of completion of continuing education as established by 201 KAR 6:070.

(10) An inactive licensee shall renew his or her inactive license biennially by submitting an application on the Renewal [Inactive Renewal and Reactivation] Form and submitting payment of the fee established in 201 KAR 6:060.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Renewal Form", January 2014 [August 2013]; and

(b) "Application for Licensure," January 2014 [Reinstatement Application", August 2013; and

(c) "Inactive Renewal and Reactivation Form", August 2013].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Licensure for Long-Term Care Administrators, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

GREG WELLS, Board Chair

APPROVED BY AGENCY: January 2, 2014

FILED WITH LRC: January 9, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 at 8:30 a.m. (EST) at 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing

may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 pm on February 28, 2014. 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: Jennifer Hutcherson, Board Administrator, Board of Licensure for Long Term Care Administrators, PO Box 1360, Frankfort, Kentucky 40602, phone 502-564-3296.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Michael West

(1) Provide a brief summary of

(a) What this administrative regulation does: This regulation establishes other requirements for renewal of a license as a long term care administrator.

(b) The necessity of this administrative regulation: This regulation is necessary to implement the provisions of KRS 216A.070(1)(a).

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity KRS 216A.070(3).

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will help the public in understanding the requirements for renewing a license as a long term care administrator.

(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 edits the forms used for the administration of this regulation.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure the requirements for licensure are understood per the forms.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation is in conformity as the authorizing statute that gives the board the ability to promulgate regulations generally and to utilize forms to fulfill the process of those regulations.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation will assist the board by making the process of the Board more easily understandable.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately 800 individuals are licensed by the Board. This regulation primarily relates to future unidentified applicants for temporary permits.

(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 licensees will need to become familiar with the processes for renewing a license.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): None.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will more readily understand the process they are to complete.

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

(a) Initially: No new costs will be incurred by the changes.

(b) On a continuing basis: No new costs will be incurred by the changes.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The board's operations are funded by fees paid by licensees.

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

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation does not establish any new fees. Nor does it increase any existing fees.

(9) TIERING: Is tiering applied? Tiering is not applied to this regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Licensure for Long Term Care Administrators.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 216A.070(3).

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(a) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None

(c) How much will it cost to administer this program for the first year? None

(d) How much will it cost to administer this program for subsequent years? None

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET

Board of Licensure for Long Term Care Administrators (Amendment)

201 KAR 6:050. Licensure by endorsement.

RELATES TO: KRS 216A.130

STATUTORY AUTHORITY: KRS 216A.070(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216A.070(3) authorizes the Board of Licensure for Long-term Care Administrators to promulgate administrative regulations necessary for the proper performance of its duties. KRS 216A.130 authorizes the board to issue a license to a long-term care administrator possessing a license issued by another state. This administrative regulation establishes the requirements for issuance of a license by endorsement.

Section 1. An applicant applying for licensure via endorsement shall cause to be submitted[submit] to the board:

(1) A completed Application for[Endorsement] Licensure;

(2) A completed Endorsement Form;

(3) Verification that the applicant:

(a) Meets all current requirements for licensure as established by KRS 216A.130; or

(b) Is currently designated as a certified long-term care administrator by the American College of Health Care Administrators;

(4)[(3)] Payment of the fee for licensure by endorsement as established by 201 KAR 6:060; and

(5)[(4)] Documentation from the other state's board verifying that the license issued by that other state:

(a) Is active;

(b) Is valid;

(c) Is in good standing;

(d) Does not have an unresolved complaint pending against it; and

(e) Has not been subject to disciplinary action during the five (5) years immediately preceding the application.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Application for[Endorsement] Licensure", January 2014; and

(b) "Endorsement Form", January 2014[October 2013, is incorporated by reference].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Licensure for Long-Term Care Administrators, 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 p.m. on February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

GREG WELLS, Board Chair

APPROVED BY AGENCY: January 2, 2014

FILED WITH LRC: January 9, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 at 8:30 a.m. (EST) at 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 p.m. on February 28, 2014. 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: Jennifer Hutcherson, Board Administrator, Board of Licensure for Long Term Care Administrators, PO Box 1360, Frankfort, Kentucky 40602, phone 502-564-3296.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Michael West

(1) Provide a brief summary of

(a) What this administrative regulation does: This regulation establishes other requirements for licensure as a long term care administrator via endorsement.

(b) The necessity of this administrative regulation: This regulation is necessary to implement the provisions of KRS 216A.130 which allows the Board to license individuals via endorsement.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity KRS 216A.070(3).

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will help the public in understanding the requirements for becoming licensed via endorsement.

(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 edits the forms used for the administration of this regulation.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure the requirements for licensure are understood per the forms.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation is in conformity as the authorizing statute that gives the board the ability to promulgate regulations generally and to utilize forms to fulfill the process of those regulations.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation will assist the board by making the process of the Board more easily understandable.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately 800 individuals are licensed by the Board. This regulation primarily relates to future unidentified applicants for temporary permits.

(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 individuals referenced above will not be impacted because they already hold licenses.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): None.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will more readily understand the process they are to complete.

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

(a) Initially: No new costs will be incurred by the changes.

(b) On a continuing basis: No new costs will be incurred by the changes.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The board's operations are funded by fees paid by licensees.

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

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation does not establish any new fees. Nor does it increase any existing fees.

(9) TIERING: Is tiering applied? Tiering is not applied to this regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Licensure for Long Term Care Administrators.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 216A.070(3).

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(a) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(b) How much revenue will this administrative regulation generate for the state or local government (including cities,

counties, fire departments, or school districts) for subsequent years? None

(c) How much will it cost to administer this program for the first year? None

(d) How much will it cost to administer this program for subsequent years? None

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET

Board of Licensure for Long Term Care Administrators (Amendment)

201 KAR 6:070. Continuing education requirements.

RELATES TO: KRS 216A.090

STATUTORY AUTHORITY: KRS 216A.070(3), 216A.090

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216A.070(3) authorizes the Board of Licensure for Long-term Care Administrators to promulgate administrative regulations necessary for the proper performance of its duties. KRS 216A.090 authorizes the board to promulgate an administrative regulation requiring a licensed nursing home administrator to complete continuing education requirements as a condition of renewal of licensure. This administrative regulation delineates the requirements for continuing education and prescribes methods and standards for the accreditation of continuing education courses.

Section 1. Definitions. (1) "Approved" means recognized by the Kentucky Board of Licensure for Long-Term Care Administrators.

(2) "Continuing education hour" means sixty (60) clock minutes of participation in a continuing educational experience.

(3) "Program" means an organized learning experience planned and evaluated to meet behavioral objectives, including an experience presented in one (1) session or in a series.

(4) "Provider" means an organization approved by the Kentucky Board of Licensure for Long-Term Care Administrators for providing a continuing education program.

(5) "Relevant" means having content applicable to the practice of long term care[nursing home] administration.

Section 2. Accrual of Continuing Education Hours; Computation of Accrual. (1) A minimum of thirty (30) continuing education hours shall be accrued by each person holding licensure during the two (2) year period for renewal.

(2) All continuing education hours shall be in or related to the field of long-term care administration.

(3) A maximum of fifteen (15) continuing education hours may be accrued during one (1) calendar day.

Section 3. Methods of Acquiring Continuing Education Hours. Continuing education hours applicable to the renewal of the license shall be directly related to the professional growth and development of a long-term care administrator. A continuing education hour shall be earned by completing an educational activity described in this section. (1) Programs not requiring board review and approval. An educational program shall be considered relevant to the practice of long-term care administration and shall be approved without further review by the board if it is:

(a) Sponsored or approved by the National Association of Long-Term Care Administrator Boards (NAB) or another board of licensure which is a member of NAB; or

(b) Sponsored by:

1. Leading Age, or any of its affiliated state chapters;

2. The American College of Health Care Administrators, or any of its affiliated state chapters;

3. The American College of Healthcare Executives;

4. The American Health Care Association, or any of its

affiliated state chapters;

5. The American Hospital Association, or any of its affiliated state chapters;

6. The Kentucky Board of Nursing; or

7. The American Medical Directors Association, or any of its affiliated chapters.

(2) Programs requiring board review and approval. A relevant program from one (1) of the following sources shall be approved by the board:

(a) A college course directly related to business administration, economics, marketing, computer science, social services, psychology, gerontology, or health professions including nursing or premedicine, except that a college course described in this paragraph shall not fulfill more than one-half (1/2) of a licensee's continuing education requirement;

(b) A relevant program, including a home study course or in-service training provided by another organization, education institution, or other service provider approved by the board;

(c) A relevant program or academic course presented by the licensee. A presenter of a relevant program or academic course shall earn full continuing education credit for each contact hour of instruction, not to exceed one-half (1/2) of the continuing education renewal requirements. Credit shall not be issued for repeated instruction of the same course; or

(d) Authoring an article in a relevant, professionally recognized or juried publication. Credit shall be granted for an article that was published within the two (2) year period immediately preceding the renewal date if the licensee has not received credit for another publication during that renewal period. A licensee shall earn one-half (1/2) of the continuing education hours required for a relevant publication.

Section 4. Procedures for Approval of Continuing Education Programs. A course which has not been preapproved by the board may be used for continuing education if approval is secured from the board for the course. In order for the board to adequately review this program, the licensee requesting approval shall submit:

(1) A published course or similar description;

(2) Names and qualifications of the instructors;

(3) A copy of the program agenda indicating hours of education, coffee breaks, and lunch breaks;

(4) Number of continuing education hours requested;

(5) Official certificate of completion or college transcript from the sponsoring agency or college;

(6) Application for Continuing Education; and

(7) The fee required by 201 KAR 6:060, Section 7.

Section 5. Procedures for Preapproval of Continuing Education Sponsors and Programs. (1) Sponsor approval.

(a) Any entity seeking to obtain approval of a continuing education program prior to its offering shall apply to the board at least sixty (60) days in advance of the commencement of the program, and shall provide the information required in Section 4 of this administrative regulation.

(b) An applicant shall satisfy the board that the entity seeking this status:

1. Consistently offers programs which meet or exceed all the requirements set forth in Section 2 of this administrative regulation; and

2. Does not exclude any licensee from its programs.

(2) A continuing education activity shall be qualified for approval if the board determines the activity being presented:

(a) Is an organized program of learning;

(b) Pertains to subject matters which integrally relate to the practice of long term care[nursing home] administration;

(c) Contributes to the professional competency of the licensee; and

(d) Is conducted by individuals who have relevant educational training or experience.

Section 6. Responsibilities and Reporting Requirements of Licensees. (1) Each licensee shall be responsible for obtaining required continuing education hours. The licensee shall:

- (a) Identify his or her own continuing education needs;
- (b) Take the initiative in seeking continuing professional education activities to meet these needs; and
- (c) Seek ways to integrate new knowledge, skills, and attitudes.

(2) Each person holding licensure shall:

- (a) Select approved activities by which to earn continuing education hours;
- (b) Submit to the board, if applicable, a request for continuing education activities requiring approval by the board as established in Section 4 of this administrative regulation;
- (c) Maintain his or her own records of continuing education hours;
- (d) At the time of renewal, list the continuing education hours obtained during that licensure renewal period; and
- (e) At the time of renewal, furnish documentation of attendance and participation in the number of continuing education hours required by Section 2 of this administrative regulation and as required by this paragraph.

1. Each person holding licensure shall maintain, for a period of two (2) years from the date of renewal, all documentation verifying successful completion of continuing education hours.

2. During the two (2) year licensure renewal period, up to fifteen (15) percent of all licensees shall be required by the board to furnish documentation of the completion of the number of continuing education hours, required by Section 2 of this administrative regulation, for the current renewal period.

3. Verification of continuing education hours shall not otherwise be reported to the board.

4. Documentation shall take the form of official documents including:

- a. Transcripts;
 - b. Certificates;
 - c. Affidavits signed by instructors; or
 - d. Receipts for fees paid to the sponsor.
5. Each licensee shall retain copies of the documentation.\

Section 7. Responsibilities and Reporting Requirements of Providers. (1) A provider of continuing education not requiring board approval shall be responsible for providing documentation, as established in Section 4 of this administrative regulation, directly to the licensee.

(2) A provider of continuing education requiring board approval shall be responsible for submitting a course offering to the board for review and approval before listing or advertising that offering as approved by the board.

Section 8. Board to Approve Continuing Education Hours; Appeal when Approval Denied. (1) If an application for approval of continuing education hours is denied, the licensee may request reconsideration by the board of its decision.

(2) The request shall be in writing and shall be received by the board within thirty (30) days after the date of the board's decision denying approval of continuing education hours.

Section 9. Waiver or Extensions of Continuing Education. (1) The board may, in an individual case involving medical disability, illness, or undue hardship as determined by the board, grant a waiver of the minimum continuing education requirements or an extension of time within which to fulfill the requirements or make a required report.

(2) A written request for waiver or extension of time involving medical disability or illness shall be submitted by the person holding a license and shall be accompanied by a verifying document signed by a licensed physician.

(3) A waiver of the minimum continuing education requirements or an extension of time within which to fulfill the continuing education requirements shall be granted by the board for a period of time not to exceed one (1) calendar year.

(4) If the medical disability or illness upon which a waiver or extension has been granted continues beyond the period of the waiver or extension, the person holding licensure shall reapply for the waiver or extension.

Section 10. Continuing Education Requirements for Reinstatement or Reactivation of Licensure. (1) A person requesting reinstatement or reactivation of licensure shall submit evidence of thirty (30) hours of continuing education within the twenty-four (24) month period immediately preceding the date on which the request for reinstatement or reactivation is submitted to the board.

(2) Upon request by a licensee, the board may permit the licensee to resume practice, with the provision that the licensee shall receive thirty (30) hours continuing education within six (6) months of the date on which the licensee is approved to resume practice.

(3) The continuing education hours received in compliance with this section shall be in addition to the continuing education requirements established in Section 2 of this administrative regulation and shall not be used to comply with the requirements of that section.

Section 11. Incorporation by Reference. (1) "Application for Continuing Education", January 2014~~[August 2013]~~, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Licensure for Long-Term Care Administrators, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

GREG WELLS, Board Chair

APPROVED BY AGENCY: January 2, 2014

FILED WITH LRC: January 9, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 at 8:30 a.m. (EST) at 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 p.m. on February 28, 2014. 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: Jennifer Hutcherson, Board Administrator, Board of Licensure for Long Term Care Administrators, PO Box 1360, Frankfort, Kentucky 40602, phone 502-564-3296.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Michael West

(1) Provide a brief summary of

(a) What this administrative regulation does: This regulation establishes continuing education requirements for the renewal of a license.

(b) The necessity of this administrative regulation: This regulation is necessary to implement the provisions of KRS 216A.090 which allows the Board require continuing education.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity KRS 216A.070(3).

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will help licensees understand continuing education requirements.

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

(a) How the amendment will change this existing administrative regulation: The amendment edits the forms used for the administration of this regulation.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to ensure the requirements for licensure are understood per the forms.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation is in conformity as the authorizing statute that gives the board the ability to promulgate regulations generally and to utilize forms to fulfill the process of those regulations.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation will assist the board by making the process of the Board more easily understandable.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately 800 individuals are licensed by the Board. This regulation primarily relates to future unidentified applicants for temporary permits.

(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 individuals referenced above will need to comply with the continuing education requirements in order to renew their licenses.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): None.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will more readily understand what types of continuing education courses are acceptable.

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

(a) Initially: No new costs will be incurred by the changes.

(b) On a continuing basis: No new costs will be incurred by the changes.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The board's operations are funded by fees paid by licensees.

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

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation does not establish any new fees. Nor does it increase any existing fees.

(9) TIERING: Is tiering applied? Tiering is not applied to this regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Licensure for Long Term Care Administrators.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 216A.070(3).

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(a) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. None

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent

years? None

(c) How much will it cost to administer this program for the first year? None

(d) How much will it cost to administer this program for subsequent years? None

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET Licensing Board for Specialists in Hearing Instruments (Amendment)

201 KAR 7:015. Fees.

RELATES TO: KRS 334.050, 334.080, 334.090, 334.110

STATUTORY AUTHORITY: KRS 334.050, 334.080, 334.090, 334.110, 334.150

NECESSITY, FUNCTION, AND CONFORMITY: This administrative regulation is necessitated by KRS 334.050, 334.080, 334.090 and 334.110 and sets forth in detail all fees charged by the board.

Section 1. Application Fees Schedule. The following fees shall be paid in connection with all types of hearing instrument specialist applications:

(1) The application fee for an apprentice permit shall be \$100 that is non-refundable[dollars].

(2) The application fee for a license shall be \$100 that is non-refundable[dollars].

Section 2. Examination Fees. The following fees shall be paid in connection with the licensure examinations required by the board:

(1) The fee for the National Institute for Hearing Instrument Studies Examination shall be ninety-five (95) dollars.

(2) The fee for all portions of the state examination shall be \$150[dollars].

(3) The fee for an individual portion of the state examination shall be thirty (30) dollars per portion.

Section 3. Original License Fees. The original license fee shall be \$200 for an applicant who successfully completes all examinations. The fee shall be paid within thirty (30) days of notification from the board that the applicant passed all examinations[portions of the examination and application processes].

Section 4. Renewal Fees and Penalties. A person holding a license shall not practice in this state after March 2 of the year in which the license is to be renewed unless the license has been renewed as provided by law and payment of the prescribed fee has been made. A license not renewed by March 2 following the expiration date shall be deemed expired and a person holding an expired license shall not engage in the practice of fitting and selling hearing instruments. The following fees and penalties shall be paid in connection with licensure renewals and penalties:

(1) The renewal fee for licensure shall be \$200.

(2) The late renewal fee, including penalty, for the grace period extending from January 31 to March 2 shall be \$250.

(3) The ~~renewal~~ fee for renewal of licensure after March 2, including penalty, shall be \$300.

(4) The fee for renewal of an apprentice permit shall be \$100.

MICHAEL STONE, Chairperson

APPROVED BY AGENCY: January 8, 2014

FILED WITH LRC: January 9, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on

February 25, 2014 at 11:00 a.m. Eastern Time at the Office of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by 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 wished to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until 11:59 p.m. on February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Angela Evans, Board Counsel, 700 Capital Avenue, Suite 118, Frankfort, Kentucky 40601, phone (502) 696-5300, fax (502) 564-6801.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Angela Evans

(1) Provide a brief summary of:

(a) What this administrative regulation does: The regulation establishes the fees to obtain and renew a license or apprentice permit.

(b) The necessity of this administrative regulation: This regulation is necessary because it sets forth the fees charged by the Board for licensure and permits.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The board is given the authority to establish the fees for licensure and permits.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation sets forth the application, examination, apprentice and licensing fees for applicants.

(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 will require the licensure fee to be paid within thirty (30) days of the applicant being notified that the applicant passed all the required exams. It also clearly states the renewal fee for the apprentice permit.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to prevent applicants from delaying paying the licensure fee and to improve the administrative efficiency in tracking the licensed issued. It is also clarifies the fee to renew permits.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the authorizing statute as it explains when the fee for original licensure is due and clarifies the renewal fee for apprentice permits.

(d) How the amendment will assist in the effective and administration of the statutes: The amendment will prevent applicants from delaying sending payment for their original license, which will assist administrative staff in maintaining better records and reducing a backlog of licenses that are pending being issued.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Currently there are approximately thirty (30) apprentices.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this 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 the administrative regulation or amendment: The apprentices will be required to pay the licensing fee within thirty (30) days of being notified they have passed all examinations instead of being able to pay for a license at their leisure.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in

question (3): The permit renewal fee is \$100, which is the same amount it has been for numerous years.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Licenses will be fully licensed sooner, allowing them to fully practice as hearing instrument specialists without the required supervision

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

(a) Initially: No fee is needed to implement the amendment.

(b) On a continuing basis: No fee is needed 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 board's operation is funded by the fees paid by licensees and apprentice applicants.

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

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation establishes the fees for licensure and permits. The amendment clarifies the apprentice renewal fee that has been in place for years but does not increase that fee or any other fee in the regulation.

(9) TIERING: Is tiering applied? Tiering was not applied because all apprentices are required to have a permit regardless of their stage in supervision and all licensees are the property of the individual thus all licensees pay the same fee.

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? Beyond the Board for Specialists in Hearing Instruments, no other unit, part or division of state or local government will be impacted.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 334.080.

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 revenue generated depends on the number of apprentices who elect to renew their permits. If all apprentices renew, the revenue will be \$3,000 for the board.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments or school districts) for subsequent years? The revenue generated depends on the number of apprentices who elect to renew. There have been as few as ten (10) apprentices, generating \$1,000 up to thirty (30) apprentices, generating \$3,000 for the board.

(c) How much will it cost to administer this program for the first year? The board is charged an administrative fee of \$50,300 by the Office of Occupations & Professions.

(d) How much will it cost to administer this program for subsequent years? The cost is expected to remain the same for the next fiscal year.

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

Revenues (+/-): N/A

Expenditures (+/-): N/A

Other Explanation: N/A

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(Amendment)

201 KAR 14:015. Retaking of examination.

RELATES TO: KRS 317.440, 317.450, 317.570

STATUTORY AUTHORITY: KRS 317.440(1)(e)(f)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.440(1)(e)(f) requires the board to promulgate an administrative regulation pertaining to exam requirements for the Kentucky Board of Barbering. This administrative regulation establishes the conditions if an examinee fails and assures the examinees of the opportunity of retaking the examination.

Section 1. Probationary License Examination Requirements.

(1) An applicant shall pass each portion of the probationary examination with a score of at least seventy-five (75) percent.

(2)(a) Except as provided by paragraphs (b) and (c) of this subsection, an applicant who does not successfully complete one (1) portion of the probationary exam shall reapply to sit for the failed portion only.

(b) A passing score on one (1) portion of the probationary exam shall only be used for a period of one (1) year to exempt the applicant from retaking that portion of the examination.

(c) An applicant who has failed one (1) or more portions of the probationary examination [apprentice examinations] two (2) consecutive times shall return to school for eighty (80) additional hours of training prior to being accepted for retake of the entire examination [the third time]. Each unsuccessful attempt thereafter shall require eighty (80) additional hours of training in school and then retake of the entire examination [1) An applicant who has failed one (1) portion of the apprentice exam may reapply to sit for:

(a) The entire exam; or

(b) The failed portion only.

(2) A passing score on one (1) portion of the apprentice exam shall only be used for a period of one (1) year to exempt the applicant from retaking that portion of the examination].

Section 2. An examination fee shall be required for each examination as required by 201 KAR 14:180.

Section 3. Instructor License Examination Requirements. (1)

An applicant who has failed one (1) or more portions of the instructor exam may reapply to sit for:

(a) The entire exam; or

(b) The failed portion or portions only.

(2) A passing score on one (1) or more portions of the instructor exam shall only be used for a period of one (1) year to exempt the applicant from retaking that portion or portions of the examination.

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014 at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis L. Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes conditions if an examinee fails and assures examinee the opportunity of retaking the examination.

(b) The necessity of this administrative regulation: 201 KAR 14:015 requires the board to recognize the probationary barber and remove apprentice barber as required by changes in the law and sets new requirements for passing exams.

(c) How this administrative regulation conforms to the content of the authorizing statutes: It establishes the probationary barber and removes apprentice barber, and sets requirements for passing exams as established by KRS 317.440, KRS 317.450 and KRS 317.570.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It removes apprentice barber from the language and sets criteria for retaking exams.

(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 removes the word apprentice from law and replaces it with probationary barber and requires a seventy-five (75) percent passing grade on each portion of the probationary barber exam to pass.

(b) The necessity of the amendment to this administrative regulation: This amendment removes the word apprentice barber from the law and replaces it with probationary barber and establishes conditions if an examinee fails and assures the examinee the opportunity of retaking the exam.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing examinations as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: By establishing the conditions required to pass the exam and replace the word apprentice barber with probationary barber.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately 166 currently attending barber colleges and the nine (9) schools licensed with 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: Exam candidates will be required to become probationary barbers not apprentice barbers and testing scores on exams will be based on a passing grade for each portion of exam not based on an average.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): It will cost them the price of the exam which is currently set at \$150.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The examinee will be a better barber for having to pass both portions of the exam instead of getting an average score in order to pass.

(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:

There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? No, all barbers licensed by this board must meet the same 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? This administrative regulation will impact the Kentucky Board of Barbering and all examinees pursuant to KRS 317.450 (1).

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 317.440 authorizes the Kentucky Board of Barbering to promulgate 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? \$0

(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? \$0

(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? No new costs will be incurred to administer this administrative regulation amendment 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: 201 KAR 14:015 will not create any new revenues for either the agency or State Government.

GENERAL GOVERNMENT CABINET Kentucky Board of Barbering (Amendment)

201 KAR 14:030. Five (5) year expiration of license.

RELATES TO: KRS 317.410, 317.450

STATUTORY AUTHORITY: KRS 317.440, 317.450

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.450 requires the board to license barbers and authorizes the board to renew a license that has not been expired more than five (5) years. This administrative regulation establishes the requirements for a barber[~~gives an opportunity to barbers~~] whose license has been expired over five (5) years to become relicensed.

Section 1. If[When] a license has been expired for more than five (5) years, the requirements established in this section shall be met.[following is required:] (1) A barber shall[must] pass both the practical and written[science] examination.

(2) A probationary[An apprentice] barber shall[must] complete 150 additional hours in training in an accredited school of barbering and pass the practical and written[science] examinations to be issued a probationary[an apprentice] license.

(3) A teacher shall[must] pass both practical and

written[science] examinations as prescribed by the board.

FRANCIS L. SIMPSON, Chair

APPROVED BY THE BOARD: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation gives an opportunity to barbers whose license has been expired over five (5) years to become relicensed.

(b) The necessity of this administrative regulation: 201 KAR 14:030 changes language in regulations as required by law, removing apprentice barbers and replacing with probationary barbers. Also changes science exam to written exam.

(c) How this administrative regulation conforms to the content of the authorizing statutes: It establishes the word probationary barber and removes apprentice barber and it also changes the science to written when referring to the exam as established by KRS 317.440.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It removes apprentice barber from language and changes science to written examination.

(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 removes apprentice from law and replaces it with probationary barber.

(b) The necessity of the amendment to this administrative regulation: 201 KAR 14:030 removes apprentice barber as required by law.

(c) How the amendment conforms to the content of the authorizing statutes: Establishes the requirement by deleting apprentice language.

(d) How the amendment will assist in the effective administration of the statutes: This replaces apprentice barber with probationary barber as required by law.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately a dozen formerly licensed barbers seek licensure after five years.

(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 individuals will receive education

and take the necessary examination to receive a license

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$150 for testing.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The applicant will be licensed as a barber

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

(a) Initially: The board examines individuals on a routine basis and these individuals would be tested on those dates, so no new costs are required to implement the regulation.

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? No, all barbers licensed by this board must meet the same 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 Kentucky Board of Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by administrative regulation: KRS 317.440.

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? \$150 for each examination given.

(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? \$150 for each examination given.

(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 (+/-): \$150 for each examination given

Expenditures (+/-): Per diems and travel expenses for the board members who administer the examinations and staff time to process applications for examination and licenses.

Other Explanation: The amendment will not create any new revenue for the Board.

GENERAL GOVERNMENT CABINET Kentucky Board of Barbering (Amendment)

201 KAR 14:040. Inspection of shops and schools.

RELATES TO: KRS 317.440(1), 317.450(2)(3), 317.590

STATUTORY AUTHORITY: KRS 317.440(1), 317.450(2)(3)

NECESSITY, FUNCTION, AND CONFORMITY: KRS

317.450(2)(3) requires the board to refuse to issue a license to a barber who has failed to comply with the provisions of KRS Chapter 317 and 201 KAR Chapter 14. KRS 317.590 authorizes disciplinary action for violations of KRS Chapter 317 and 201 KAR Chapter 14. This administrative regulation establishes requirements relating to the inspection of a barber shop or school and the information to be displayed at a barber shop or school.

Section 1. A board member or authorized agent may inspect a barber shop, manicuring establishment located within a barber shop, or a barber school to determine if the licensee is in compliance with KRS Chapter 317 and 201 KAR Chapter 14.

Section 2. A barber shop or school shall conspicuously display:

(1) The license and picture of each barber and independent contractor engaged in the practice of barbering at that shop or school;

(2) The license for the barber shop or school; and

(3) The most recent inspection sheet furnished by the board for the barber shop, independent contractor, or school. The inspection sheet shall include the telephone number and address for a consumer to use to file a complaint against a licensee.

Section 3. The owner and manager of each establishment licensed by the board shall be responsible for compliance with KRS Chapter 317 and 201 KAR Chapter 14.

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation establishes requirements relating to the inspection of a barber shop or school and the information to be displayed at a barber shop or school.

(b) The necessity of this administrative regulation: It is necessary to let shops and schools know what is expected during an inspection.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The law requires the board to regulate shops and schools.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It informs shops and schools what is required for inspections.

(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 require independent contractors to have a license and picture displayed, and indicates the responsibility of an owner and manager to ensure compliance with laws and regulations which govern the practice of barbering.

(b) The necessity of the amendment to this administrative regulation: The amendment conforms the regulation to the law by adding independent contractors and emphasized the responsibility of owners and managers.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing barber shops and schools as well as barbers and independent contractors as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: Independent contractors will be subject to the same posting requirements as employees, and owners/managers will ensure compliance with the laws and regulations to protect the public.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Around 1,100 barber shops, 900 independent contractors, 3,000 barbers and nine (9) schools are licensed with 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: An independent contractor will display a license and picture as well as the last inspection report.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$0

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be meeting the requirements of the law.

(5) Provide an estimate of how much it will cost to implement this administrative regulation: \$0

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not used because all barbers and independent contractors meet the same 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 Kentucky Board of Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. The Kentucky Board of Barbering is authorized to promulgate this administrative regulation pursuant to KRS 317.440, 317.450, and 317.590.

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. \$0

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: The amendment will not create any new revenue for the Board.

GENERAL GOVERNMENT CABINET Kentucky Board of Barbering (Amendment)

201 KAR 14:050. Probationary[Apprentice's] license; qualifications.

RELATES TO: KRS 317.450(1)(a)-(d)[- (2)]

STATUTORY AUTHORITY: KRS 317.440(1)(d), 317.450(1)(a)-(d)[- (e)]

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.450(1)(a)-(d)[317.440(1)(c)-] authorizes the board to issue probationary licenses before issuing a license to practice barbering. KRS 317.440(1)(d) authorizes the board to establish qualifications for barber schools[promulgate administrative regulations establishing the training and supervision of apprentices]. This administrative regulation establishes the process for obtaining probationary and barber licenses[a specific time period for the training and supervision of apprentice barbers].

Section 1. An applicant for a license as a probationary[an apprentice] barber who does not have proof of graduating from high school with a diploma before entering barber school shall show results:

(1) From the Test for Adult Basic Education indicating a score equivalent to the twelfth grade of high school; or

(2) Of a G.E.D. test with a score of forty-five (45) percent or better.

Section 2. A person holding a Kentucky cosmetology license shall be given credit for 750 hours toward a prescribed course of instruction at an approved school of barbering[obtaining a Kentucky apprentice barber license].

Section 3. (1) A probationary licensee[An apprentice barber] shall apply for a barber license no sooner than six (6) months of continuous service from the effective date of the probationary license[nine (9) months] and no longer than twelve (12)[eighteen (18)] months after the effective date of the probationary license[passing the apprentice examination].

(2) The board may, in individual cases involving medical disability, illness, or undue hardship as determined by the board, grant an extension of the probationary[apprentice] period.

(a) A written request for an extension of time involving medical disability or illness shall be submitted by an applicant[the apprentice] and shall be accompanied by a verifying document signed by a licensed physician.

(b) An extension of the probationary[apprentice] period shall be granted by the board for a period of time not to exceed six (6) months, upon approval of the request and payment of the requisite fee[one (1) calendar year].

(c) If the medical disability, illness, or undue hardship upon which an extension has been granted continues beyond the period of the extension, the applicant[apprentice] shall reapply for an[the]

extension.

Section 4. ~~Continuous service~~[A nine (9) month apprenticeship] consists of working with a probationary license in a Kentucky licensed barber shop [under the immediate supervision of a licensed barber] for an average of twenty (20) hours or more per week for ~~six (6) continuous~~[nine (9)] months.

FRANCIS L. SIMPSON, Chair

APPROVED BY THE BOARD: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation establishes requirements for obtaining probationary and barber licenses.

(b) The necessity of this administrative regulation: 201 KAR 14:050 changes language in the regulation as required by law, removing apprentice barbers and replacing it with probationary barbers. This regulation also adds the Test of Adult Basic Education as being acceptable to enter barber school.

(c) How this administrative regulation conforms to the content of the authorizing statutes: It establishes the word probationary barber, removes apprentice barber, and adds the Test of Adult Basic Education as being acceptable to enter barber school.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It informs barber schools of the types of documents that are needed to be considered a high school graduate and the process for obtaining a probationary and barber license.

(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 add another test considered to be acceptable for a high school graduate and removes the word apprentice to ensure compliance with the law.

(b) The necessity of the amendment to this administrative regulation: This amendment conforms the regulation to the law and adds another test considered to be acceptable for a high school graduate.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing barber schools as well as probationary barbers and barbers as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: The regulation was amended to be consistent with changes to our law.

(3) List the type and number of individuals, businesses,

organizations, or state and local governments affected by this administrative regulation: nine (9) barber schools and 111 Probationary Barbers.

(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: Instead of serving an apprenticeship, the probationary barber will work six (6) months of continuous service before being eligible to take the barber exam.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$0

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be meeting the requirements of the law.

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not used because all schools, probationary barbers and barbers licensed by this board must meet the same 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 Kentucky Board of Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 317.440 and 317.450.

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. \$0

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: The amendment will not create any new revenue for the board.

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(Amendment)

201 KAR 14:060. Licensing requirements for qualified nonresidents.

RELATES TO: KRS 317.450

STATUTORY AUTHORITY: KRS 317.440, 317.450

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.450(1)(e) authorizes the board to issue a license by endorsement to a nonresident of Kentucky. This administrative regulation establishes the licensing requirements for qualified nonresidents[, regular and apprentice].

Section 1. Any person who is at least eighteen (18) years of age and of good moral character and temperate habits, who has a current license or certificate of registration as a practicing barber of another state or other board recognizing authority, which has substantially the same requirements for licensing or registering barbers as are required of KRS Chapter 317 and the various administrative regulations adopted pursuant thereto, shall upon payment of the required fee be granted permission to take an examination to determine his fitness to receive a license to practice barbering.

Section 2. For an applicant coming from a state or other board recognizing authority without substantially the same requirements, they shall have been a registered barber and worked for three (3) years.~~[Section 3. Any apprentice who is at least sixteen and one-half (16 1/2) years of age and of good moral character and temperate habits and has a current license or a certificate of registration as an apprentice in a state or other board recognizing authority which has substantially the same requirements for licensing an apprentice as is provided in KRS Chapter 317 and the various administrative regulations adopted pursuant thereto, shall upon payment of the required fee be granted permission to take an examination to determine his fitness to receive a license as an apprentice.]~~

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation sets the licensing requirements for qualified nonresidents.

(b) The necessity of this administrative regulation: It is necessary to remove the apprentice portion of this regulation due

to statute changes in 2013.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The law requires the board to regulate barbers.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It will remove the apprentice portion of this regulation, making necessary changes due to the statute change in 2013.

(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 will allow barbers who have been licensed in another state for three years or longer to apply for endorsement.

(b) The necessity of the amendment to this administrative regulation: The amendment conforms the regulation to the law.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing barbers as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: This removes the apprentice barber as required by law.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately fifteen (15) barbers outside Kentucky apply for licensure on an annual basis.

(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: Qualified barbers will make application.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$250

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be licensed if qualified.

(5) Provide an estimate of how much it will cost to implement this administrative regulation: \$0

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? No, tiering was not used because all endorsement applicants licensed by this board must meet the same 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? This impacts the Kentucky Board of Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS Chapter 317.440, 317.450 and 317.460.

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. \$0

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: No revenues will be generated or expended.

**GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(Amendment)**

201 KAR 14:065. Place of business requirements.

RELATES TO: KRS 317.440, 317.450

STATUTORY AUTHORITY: KRS 317.410, 317.420, 317.440

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.440(1) requires the board to promulgate an administrative regulation to establish requirements for barber shops or schools. This administrative regulation establishes the place of business requirements for licensees~~[Licensed places of business and to practice or teach in a licensed shop or school].~~

Section 1. Every probationary licensee~~[licensed apprentice]~~, every licensed barber, and every licensed instructor of barbering regulated by KRS Chapter 317 and 201 KAR Chapter 14~~[this chapter]~~ shall practice in a licensed barber shop or licensed barber school.

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: Establishes change of language to remove apprentice barber from regulation and replace with probationary barber for place of business

requirement.

(b) The necessity of this administrative regulation: This regulation requires the board to recognize the probationary barber and remove apprentice barber as required by changes in the law.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The law requires the board to regulate probationary barbers, barbers and instructors

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It informs all licensed probationary barbers, barbers and instructors that they need to work in a licensed shop or teach in a licensed school.

(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 removes apprentice from law and replaces it with probationary barber.

(b) The necessity of the amendment to this administrative regulation: The amendment conforms the regulation to the law by adding probationary barber and removing apprentice.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing barber shops and schools as well as barbers and probationary barbers as established in KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will make the regulation consistent with the law.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: 1,100 shops, nine (9) schools, 3,000 barbers and 111 probationary barbers licensed with 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: It requires probationary barbers to work in a licensed barber shop.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$0

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be meeting the requirements of the law.

(5) Provide an estimate of how much it will cost to implement this administrative regulation: \$0

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not used because all barbers, probationary barbers, and instructors meet the same 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? This will impact the Kentucky Board of Barbering.

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

regulation. The Kentucky Board of Barbering is authorized to promulgate this administrative regulation pursuant to KRS 317.410, 317.420 and 317.440.

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. \$0

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: The amendment will not create any new revenue or expenditures for the board.

GENERAL GOVERNMENT CABINET **Kentucky Board of Barbering** **(Amendment)**

201 KAR 14:085. Sanitation requirements.

RELATES TO: KRS 317.410, 317.440

STATUTORY AUTHORITY: KRS 317.410, 317.440

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.440 requires the board to establish requirements to protect the health and safety of the public. This administrative regulation establishes the sanitation requirements.

Section 1. Any barber, probationary licensee[~~apprentice barber~~], student barber, manicurist, or instructor of barbering suffering from any contagious diseases or conditions shall not be allowed to practice in this state. No person suffering from a contagious disease or condition shall be rendered service by any barber, probationary licensee[~~apprentice barber~~], student barber, manicurist, or instructor of barbering in the state.

Section 2. General Sanitation. The entire licensed facility, barber shops, and barber schools, including all equipment, employees, and implements contained therein shall be continually maintained in a sanitary manner satisfactory to the board.

Section 3. Methods of Sanitizing. (1) Any implements to be used on the public shall be properly sanitized and all methods of sanitation shall be bacteriological effective.

(2) All commercially prepared sanitizing agents shall be used in accordance with the manufacturer's instructions.

Section 4. Disinfection of Implements and Spills; Blood and Body Fluids. (1) Disinfectants are inactivated and ineffective when visibly contaminated with debris, hair, dirt, particulates or when heavily soiled; thus, implements and surfaces shall first be thoroughly cleaned prior to disinfection.

(a) Disinfectants shall be prepared fresh daily or more often if solution becomes diluted or soiled.

(b) Contact Time: Leave surface wet or completely immersed for ten (10) minutes or longer as required by manufacturer for disinfecting against HIV, HBV, and all other viruses, bacteria, and fungi.

(2) All used implements shall first be cleaned of visible dirt, debris, or bodily fluids with warm soapy, detergent water and then disinfected by completely immersing in an appropriate disinfectant.

(a) All nonporous implements that come into contact with intact skin shall be thoroughly cleaned before immersion in an appropriate disinfectant. An appropriate disinfectant for objects that come into contact with intact skin is:

1. An Environmental Protection Agency registered, hospital-grade bactericidal (especially pseudomonacidal), virucidal, and fungicidal that is mixed and used according to the manufacturer's directions; or

2. Household bleach in a ten (10) percent solution for ten (10) minutes.

(b) All nonporous implements which have come in contact with blood or body fluids shall be thoroughly cleaned before immersion in an appropriate disinfectant. An appropriate disinfectant includes:

1. Environmental Protection Agency registered tuberculocides or products registered against HIV/HBV; or

2. Household bleach in a ten (10) percent solution for ten (10) minutes.

(c) For personal protection against blood-borne pathogens, cleanup should always be done wearing protective gloves and also gowns, and eye protection for large spills.

(d) All implements, which have come in contact with blood or body fluids, shall be disinfected by complete immersion in an appropriate disinfectant.

(3) Any nonporous surface that comes in contact with blood or body fluids shall first be cleaned with warm soapy, detergent water, and then an appropriate disinfectant shall be used.

(a) An appropriate disinfectant for surfaces which have come in contact with blood or body fluids, include:

1. Environmental Protection Agency registered tuberculocides or products registered against HIV/HBV; or

2. Household bleach in a ten (10) percent solution for ten (10) minutes.

(b) For personal protection against blood-borne pathogens, cleanup should always be done wearing protective gloves and also gowns, and eye protection for large spills.

(4) Household bleach is an effective disinfectant for all purposes in a shop or school, with the following considerations.

(a) Bleach solutions shall be mixed daily and used in a ten (10) to one (1) solution, nine (9) parts tap water and one (1) part bleach.

(b) Bleach shall be kept in a closed covered container and not exposed to sunlight.

(c) Bleach may produce eye irritation or mouth, esophageal, and gastric burns.

(d) Bleach is corrosive to metals.

(e) Bleach vapors might react with vapors from other chemicals, and therefore should not be placed or stored near other chemicals used in salons (i.e. acrylic monomers, alcohol, other disinfecting products, or near flame).

(f) Used or soiled bleach solution shall be discarded every day by pouring the solution down a sink basin or toilet bowl.

(5) A bottle container other than the original manufacturer's container used for application of appropriate disinfectant shall be properly labeled as to contents, percentage solution, and date mixed.

(6) Cleanup items from minor cuts shall be double bagged or placed in biohazard containers. Licensees should consult with the local health department for directions about disposal.

(7) All Food and Drug Administration designated "medical devices" shall only be disinfected by appropriate Environmental Protection Agency approved disinfectants.

(8) Environmental Protection Agency approved disinfectants are indicated by their registration number on the product label and the manufacturer's directions for use shall always be followed.

Section 5. Shampoo Bowls. All shampoo bowls, shampoo boards, cups, or similar items shall be sanitized after each use.

Section 6. Proper Protection of Neck. (1) No shampoo apron, hair cloth, or similar article shall be placed directly against the neck of the patron, and they shall be kept from direct contact with the patron by means of a paper neck band or clean towel.

(2) No neck band of paper or cloth shall be used more than once.

(3) No towel shall be used more than once without proper laundering.

Section 7. Use of Creams. (1) All creams and other semi-solid substances shall be removed from containers with a clean, sanitized spatula.

(2) Spatulas made of a washable, nonabsorbent material shall be sanitized before being used again.

(3) Spatulas made of wood shall be discarded after one (1) use.

Section 8. Use of Styptics. Styptics to arrest bleeding shall be used only in liquid or powder form and shall be applied by clean gauze, cotton, or any other sanitary item.

Section 9. Special Solution Containers. Product containers shall be used to prevent the contamination of unused solution.

Section 10. Use of Powder. All powder shall be dispensed from a shaker or similar receptacle and shall be applied with disposable puffs or cotton pledgets, or other disposable applicators.

Section 11. Walls and Floors. Walls, floors, and fixtures shall be sanitary and kept clean at all times.

Section 12. Proper Laundering Methods. (1) All cloth towels, robes, and similar items shall be laundered in a washing machine with laundry detergent and chlorine bleach used according to the manufacturer's directions for sanitation purposes.

(2) A closed, dustproof cabinet must be provided for clean towels and linen, and a closed, dustproof hamper or receptacle must be provided for all soiled towels and linens.

Section 13. Personal Hygiene. (1) Every person licensed or permitted by the board shall thoroughly cleanse his or her hands with soap and water or an alcohol-based hand rub immediately before serving each patron.

(2) All licensees shall wear a clean, washable outer garment while serving a patron in a shop.

(3) Instruments or implements shall not be carried or stored in pockets, belts, aprons, or smocks.

Section 14. Equipment Sanitation. (1) All equipment used in a shop shall be maintained in a sanitary manner.

(2)(a) Electrical equipment that provides circulating, whirlpool, or vacuum effects (for example, a facial machine, pedicure station, and nail drill) shall be:

1. Cleaned and disinfected after each use; and
2. Flushed, cleaned, and disinfected on a bi-weekly schedule.

(b) A record of such cleaning log shall be kept and made available upon any shop inspection.

(c) A bi-weekly cleaning shall include the use of a hospital grade disinfectant or ten (10) percent bleach solution that is circulated through the machine for the minimum time recommended by the manufacturer.

(3)(a) Heated electrical equipment such as thermal irons, pressing combs, and stoves are sanitized by the heat source.

(b) Unheated parts of heated electrical equipment shall be cleaned and disinfected according to manufacturers' recommendations.

(c) Any other electrical equipment such as clippers and attachments shall be cleaned and disinfected after each use using the following method:

1. Remove hair and all foreign matter from the equipment; and
2. Completely saturate clipper blade and attachment with an EPA-registered high-level disinfectant solution, spray, or foam used according to the manufacturer's instructions.

Section 15. Rooms used for multiple purposes such as massage are permissible as long as all instruments, implements, and supplies are properly sanitized. [All barber shops or barber schools, together with all furniture, equipment, tools, utensils, floors, walls, ceilings, restrooms, supply rooms, adjoining rooms

and manicuring instruments shall at all times be kept in a clean and sanitary condition.

Section 3. Each operator engaged in scalp work of any kind must have at least six (6) combs at his or her disposal and more are recommended. Each work stand shall have a bottle of alcohol (ethyl alcohol – seventy (70) percent) and cotton on same for the purpose of cleaning scissors, razors, clippers, and all instruments before and after being used on a customer.

Section 4. Any barber, manicurist, student, or instructor shall wash his or her hands in soap and water before beginning work on any and each patron or person.

Section 5. At least one (1) covered waste receptacle for every two (2) chairs must be provided in each barber shop or barber school for the deposit of soiled towels. An additional waste receptacle for each two (2) chairs must be provided for deposit of used paper products.

Section 6. (1) Towels shall not be used for more than one (1) operation. Towels not sent to a steam laundry must be boiled in water. Laundry work in shop or school is prohibited in the room where barber service is rendered. Drying of towels or linens on lines or radiators in schools or shops is prohibited.

(2) The headrest of each chair must be provided with a clean towel or sheet of clean paper for each patron.

(3) A strip of cotton, towel or paper must be placed around the patron's neck so that the chair cloth does not come in contact with the skin of the neck. Such papers, towel or cloth must be discarded after use on a patron.

Section 7. The use of powder puffs, sponges, lump alum and styptic pencils is prohibited.

Section 8. Razors, scissors, tweezers, combs, rubber discs and parts of vibrators and all other utensils, appliances or anything that comes in contact with the head, face, neck or hands, must be washed with hot water and soap and disinfected, and then placed in a dry sterilizer until again used. Only such methods of disinfection as are bacteriologically effective and approved by the Secretary of the Human Resources Cabinet shall be permitted. The secretary has approved the following methods of disinfection:

(1) Dry disinfection:

(a) Formaldehyde gas has a place in disinfecting valuable articles, but it has no penetrating power and is limited in its action to the surface. Further it requires a temperature of sixty-five (65) degrees Fahrenheit or over and a humidity of at least sixty (60) percent to be effective. Exposure of at least six (6) to twelve (12) hours in a small type cabinet to strong concentration of the gas is necessary to achieve surface disinfection. Formaldehyde gas cannot be depended upon to accomplish more than surface disinfection under optimistic conditions.

(b) Dry heat and temperature of 338 degrees Fahrenheit continued for one (1) hour will destroy all form of bacterial life. It is easy to maintain this temperature in an appliance of special construction known as a hot air or dry wall sterilizer. The ordinary household cooking oven is as good as any special contrived appliance for the disinfection of small articles by dry heat. In the absence of a thermometer, it is usual to heat the oven to a point necessary to brown cotton and expose the object for at least one (1) hour to this heat.

(2) Liquid disinfection.

(a) Carbolic acid and phenol are useful disinfectants in five (5) percent solutions (seven (7) ounces to one (1) gallon of water) with exposure for one-half (1/2) hour. They are effective against all ordinary harmful bacteria.

(b) Sodium Hypochlorite solutions made up from commercial preparations and containing 200 ppm of chlorine are effective for the surface disinfection of equipment that has been thoroughly cleaned. Contact with the solution should not be for less than two (2) minutes.

(c) A ten (10) percent solution for Formalin is satisfactory for

disinfection of all equipment. Formalin does not attack copper, nickel, zinc, or other metal substances.

(d) A seventy (70) percent solution of alcohol is an effective disinfectant for cleaning equipment.

(e) Instruments are to be disinfected by boiling water and should be boiled at least fifteen (15) minutes. (One (1) percent alkaline substance, such as carbonate of soda, will prevent rusting or injury to the cutting edge of bright steel instruments.)

(f) Steam sterilization at fifteen (15) pounds pressure at 248 degrees Fahrenheit for thirty (30) minutes is an effective means of sterilization. Steaming steam has the same disinfecting power as boiling water and exposure for one-half (1/2) hour to steaming steam is sufficient for most purposes.]

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation updates sanitation requirements for any barber, probationary licensee, student barber, manicurist or instructor.

(b) The necessity of this administrative regulation: The regulation is necessary to protect the health and safety of the public.

(c) How this administrative regulation conforms to the content of the authorizing statutes: It establishes sanitation requirements which aid in protecting the health and safety of the public.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It specifies sanitation standards.

(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: It modernizes sanitation standards.

(b) The necessity of the amendment to this administrative regulation: The standards were outdated and no longer recommended, so they needed to be brought current.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing barbers, probationary licensees, barber students and barber shops as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: It provides new standards for proper sanitation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this

administrative regulation: This change will impact the Kentucky Board of Barbering, 1,100 shops, 3,000 barbers, 111 probationary licensee, 166 barber students and nine (9) barber schools in the state.

(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: They will have to ensure that they are complying with the new sanitation requirements; most of whom are already compliant.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$0

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be meeting the new sanitation requirements and helping to protect the health and safety of the public.

(5) Provide an estimate of how much it will cost the administrative body 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: There will be no cost 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 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 nor does it increase any fees wither directly or indirectly.

(9) TIERING: Is tiering applied? Tiering was not used because all barbers, probationary licensees, barber students, shops and schools must meet the same sanitation 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 Kentucky Board of Barbering.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 317.410 and 317.440.

(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. \$0.

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: The amendment will not create any new revenue for the board.

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(Amendment)

201 KAR 14:115. Examinations; school and board.

RELATES TO: KRS 317.410, 317.440

STATUTORY AUTHORITY: KRS 317.440

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.440(1)(e) requires the board to promulgate an administrative regulation to establish examination requirements. This administrative regulation establishes examination applications and sets forth scores for passing.

Section 1. ~~A~~~~No~~ student from a barber school ~~shall not~~~~will be permitted to~~ take the board's examination ~~if that student's~~~~whose~~ application for examination has not reached the board's headquarters at least seven (7) days prior to the date of the examination.

Section 2. The board's examination ~~shall~~~~will~~ be given only to students who have been notified to appear for the examination and who are wearing a clean, washable uniform and have instruments to be used in the giving of their demonstrations.

Section 3. The board's examination ~~shall include:~~

~~(1) A written examination that covers~~~~is both written in~~ all subjects set forth in the administrative regulations relating to barbers; ~~and~~

~~(2) A practical demonstration on a living model~~~~is required as part of the examination~~.

Section 4. ~~An applicant shall pass each portion, practice and theory, of the probationary examination with a seventy-five (75) percent passing grade on the board's examination~~~~An average grade of seventy-five (75) percent in theory and practice will be required as a passing grade on the board's examination~~.

Section 5. ~~An applicant for an~~~~All applicants for~~ instructor's license ~~shall~~~~must~~ make a general average of eighty (80) percent on the board's examination.

Section 6. A student who works in a barber shop prior to passing the ~~probationary~~~~apprentice~~ examination given by the board ~~shall~~~~will~~ be considered ineligible to take the examination.

Section 7. A bulletin board ~~shall~~~~must~~ be provided by a school and the examination schedule ~~shall~~~~must~~ be conspicuously displayed thereon.

Section 8. Written and oral tests ~~shall~~~~must~~ be given at intervals by a school to determine the status of the student.

FRANCIS L. SIMPSON, Chair

APPROVED BY THE BOARD: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: It establishes examination applications and sets forth scores for passing.

(b) The necessity of this administrative regulation: This regulation specifies examination requirements.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The statute authorizes the Board to establish regulations for the examination of applicants.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It specifies examination requirements for individuals who seek 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: This amendment removes the word apprentice from law and replaces it with probationary barber and requires a seventy-five (75) percent passing grade on each portion of the probationary barber exam to pass.

(b) The necessity of the amendment to this administrative regulation: The amendment conforms the regulation to the law, and requires a seventy-five (75) percent on each portion of the probationary exam to pass.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing examinations as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: By establishing the conditions required to pass the exam and replace the word apprentice with probationary.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation. Approximately 166 barber students and nine (9) schools.

(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: Exam candidates will have to pass both sections of the exam to receive a probationary license.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$150 which is the same fee formerly.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The examinee will be a better barber for having to pass both portions of the exam instead of getting an average in order to pass. The requirement to pass each section is necessary since there is no apprenticeship under a licensed barber.

(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: There are no new costs to implement this administrative regulation because the Board already meets periodically to examine individuals.

(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 will be necessary to implement this administrative

regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any new fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? No, all applicants by this board must meet the same 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 Kentucky Board of Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 317.410 and 317.440

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? \$0 in new 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? \$0 in new, recurring revenue.

(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? No new costs will be incurred to administer this administrative regulation amendment 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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: 201 KAR 14:115 will not create any new revenues or expenditures for the board.

GENERAL GOVERNMENT CABINET Kentucky Board of Barbering (Amendment)

201 KAR 14:150. School records.

RELATES TO: KRS 317.410, 317.450, 317.540

STATUTORY AUTHORITY: KRS 317.430, 317.440(1)(b)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.440(1)(b) requires the Kentucky Board of Barbering to promulgate administrative regulations to govern quantity and quality of equipment, supplies, materials, records, and furnishings required in barber shops or schools. This administrative regulation establishes requirements for school records.

Section 1. A monthly attendance record of the entire enrollment, including full-time and part-time students and instructors, ~~and apprentice-instructors~~ shall be kept by the schools and received at the board office not later than the tenth calendar day of each month.

(1) A barber school shall be held fully responsible for the completeness and accuracy of the attendance record, which shall show the total hours obtained for the previous month and the total accumulated hours to date for all students and instructors, ~~and apprentice-instructors~~.

(2) Only the hours recorded shall be submitted each month, and that report shall not be amended without proof or error and shall be available for inspection.

(3) A copy of the student's daily attendance record for the month of graduation through the date of a student's graduation

shall be submitted with the student's certification of hours as part of the application for examination ~~as an apprentice~~ upon completion of the course.

Section 2. A copy of the monthly attendance record, as provided to the board office, shall be posted monthly on a bulletin board in the school so it is available at all times to the students, employees, board members, or agents of the board.

Section 3. (1) Barber schools shall be required to keep a record of a student's daily work, approved and signed by the instructor of each student's practical work, work performed on clinic patrons, and classroom work.

(2) This record shall be included with the student's certification of hours and application for examination ~~as an apprentice~~ upon completion of the course or with the certification of hours if a student withdraws or is dismissed from a school or upon the closure of a school and shall be available for inspection.

Section 4. (1) A detailed record shall be kept of all enrollments, withdrawals, dismissals, and graduations.

(2) Certification of hours completed, including a copy of the student's daily attendance record for the month of graduation through the date of a student's graduation, shall be forwarded with all records of a student's daily work, to the office of the board within ten (10) calendar days of a student's withdrawal, dismissal, graduation, or closure of the barber school.

Section 5. (1) All records shall be kept in a lockable file on the premises of the school and shall be available for inspection.

(2) The security of all records shall be the responsibility of the school.

(3) Records shall be locked if not in use or during nonbusiness hours.

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes requirements for school records.

(b) The necessity of this administrative regulation: This regulation removes the words apprentice and apprentice instructors as required by a statute change in 2013.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The law requires the board to regulate

barber schools.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It informs the schools what is required as far as records.

(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 removes the words apprentice and apprentice instructors from the law.

(b) The necessity of the amendment to this administrative regulation: The amendment conforms the regulation to the law by removing apprentice and apprentice instructors.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations governing schools as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: It conforms the regulation to the statutory authority.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation. Nine (9) schools are licensed with 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 schools are required to submit monthly records. The amendment does not impact the current obligation by schools.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$0

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The schools would be meeting the requirements of the law.

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? No, all schools licensed by this board must meet the same 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 Kentucky Board of Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 317.430 and 317.440

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. \$0

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: The amendment will not create any new revenue for the board.

GENERAL GOVERNMENT CABINET Kentucky Board of Barbering (Amendment)

201 KAR 14:180. License fees, examination fees, renewal fees, and expiration fees.

RELATES TO: KRS 317.410(8), 317.450

STATUTORY AUTHORITY: KRS 317.440(2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 317.440(2) requires the Board of Barbering to establish fees for licenses within the limits established by KRS 317.450. This administrative regulation establishes fees relating to barbering licenses.

Section 1. Initial licensing fees shall be as follows:

- (1) Probationary[Apprentice] license: fifty (50) dollars;
- (2) Barber license: fifty (50) dollars;
- (3) Endorsement: \$250;
- (4) Barber shop license: fifty (50) dollars;
- (5) Barber school license: \$150;
- (6) Teacher of barbering license: \$100; and
- (7) Independent contract owner: fifty (50) dollars.

Section 2. Examination fees shall be as follows:

- (1) Probationary[Apprentice] examination: \$150;
- (2) Barber examination: \$150; and
- (3) Teacher of barbering examination: \$150.

Section 3. Renewal fees shall be as follows:

- (1) Probationary licensee[Apprentice] renewal: fifty (50) dollars;
- (2) Barber renewal: fifty (50) dollars;
- (3) Teacher of barbering renewal: fifty (50) dollars;
- (4) Barber shop renewal: fifty (50) dollars;
- (5) Barber school renewal: \$150; and
- (6) Independent contract owner: fifty (50) dollars.

Section 4. (1) The late fee for renewal of a license that has been expired for more than thirty-one (31) days and not more than five (5) years from the expiration date of the last license issued by the board shall be as follows:

- (a) Probationary licensee[Apprentice] late fee: twenty-five (25) dollars;
 - (b) Barber late fee: twenty-five (25) dollars;
 - (c) Teacher of barbering late fee: twenty-five (25) dollars;
 - (d) Barber shop late fee: twenty-five (25) dollars;
 - (e) Barber school late fee: twenty-five (25) dollars; and
 - (f) Independent contract owner: twenty-five (25) dollars.
- (2) The total cost of renewal of a license governed by subsection (1) of this section shall include the renewal fee and the:
- (a) Late fee established by subsection (1) of this section; and
 - (b) Lapse fee defined by KRS 317.410(8).

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky, 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation establishes fees relating to barbering licenses.

(b) The necessity of this administrative regulation: To provide notice of fees.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation establishes fees as authorized by statute.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation lists fees charged by the board.

(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 reflects changes from apprentice barber to probationary barber.

(b) The necessity of the amendment to this administrative regulation: The amendment conforms the regulation to the law by removing the word apprentice and replacing it with probationary. The fee structure remains the same as it was before.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to establish fees.

(d) How the amendment will assist in the effective administration of the statutes: It will conform the regulation to the changes in the law regarding probationary barbers.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation. 1,100 shops, nine (9) schools, 3,000 barbers, 900 independent contractors, fifty-seven (57) instructors, 111 probationary barbers.

(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 licensee will have to pay the license fees. The total fees have not changed even though the status from apprentice barber to probationary barber has.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Shops-\$50, Schools-\$150, Barbers-\$50, Independent Contractors- \$50, Instructors- \$100 for initial/\$50 renewal and Probationary barbers-\$50

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will receive the appropriate license.

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? No, all similarly classified individuals pay the same fees.

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 Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 317.440 and 317.450.

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. \$0

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: The amendment will not create any new revenue for the board.

GENERAL GOVERNMENT CABINET Board of Nursing (Amendment)

201 KAR 20:470. Dialysis technician credentialing requirements and training program standards.

RELATES TO: KRS 314.035, 314.137

STATUTORY AUTHORITY: KRS 314.131(1), 314.137

NECESSITY, FUNCTION AND CONFORMITY: KRS 314.137 requires the board to promulgate administrative regulations to regulate dialysis technicians. This administrative regulation establishes the requirements for dialysis technician training programs and for credentialing dialysis technicians.

Section 1. Definitions. (1) "Approved dialysis technician training program" means a program to train dialysis technicians that is approved by the board.

(2) "Central venous catheter" means a catheter that is inserted in such a manner that the distal tip is located in the superior vena cava.

(3) "Dialysis technician applicant" means an individual who has applied for a dialysis technician credential.

(4) "Dialysis technician trainee" means an individual who is enrolled in an approved dialysis technician training program.

(5) "Supervision" means initial and ongoing direction, procedural guidance, observation, and evaluation by a registered nurse or physician, and when a patient is being dialyzed the registered nurse or physician is in the immediate clinical area.

Section 2. Requirements for Dialysis Technician Credential.

(1)(a) An individual who applies to be credentialed as a dialysis technician in order to engage in dialysis care shall:

1. File with the board the "Application for Dialysis Technician Credential";

2. Have completed an approved dialysis technician training program or an out-of-state dialysis training program pursuant to subsection (1)(b) of this section;

3. Pay the fee established in Section 12 of this administrative regulation;

4. Provide a criminal record check report from the Kentucky Administrative Office of the Courts, Courtnet Disposition System that is dated within six (6) months of the date of the application;

5. Provide a completed Federal Bureau of Investigation (FBI) Applicant Fingerprint Card and the fee required by the FBI that is within six (6) months of the date of the application;

6. Provide to the board a certified copy of the court record of any misdemeanor or felony conviction from any jurisdiction, except for traffic-related misdemeanors (other than DUI) or misdemeanors older than five (5) years; and

7. Provide to the board a letter of explanation that addresses each conviction.

(b)1. If the dialysis technician applicant has completed an out-of-state dialysis technician training program, the applicant shall submit the training program curriculum and evidence of completion to the board. The board or its designee shall evaluate the applicant's training program to determine its comparability with the standards as stated in Section 7 of this administrative regulation.

2. The board or its designee shall advise an applicant if the training program is not comparable and specify what additional components shall be completed to meet the requirements of Section 7 of this administrative regulation.

3. A dialysis technician applicant who has completed an out-of-state dialysis technician training program shall be required to complete that portion of a board-approved dialysis technician training program related to specific portions of the legal and ethical aspects of practice as set forth in the "Dialysis Technician Training Program Guide". An applicant shall submit evidence to the board of successful completion of the following sections:

a. State and federal regulations governing dialysis;

b. The principles and legal aspects of documentation, communication and patient rights;

c. The roles of the dialysis technician and other multidisciplinary team members; and

d. Principles related to patient safety.

4. A dialysis technician applicant who has completed an out-of-state dialysis technician training program shall submit the "Checklist for Dialysis Technician Competency Validation" signed by the applicant's immediate supervisor in Kentucky. The "Checklist for Dialysis Technician Competency Validation" shall be filed after the submission of the "Application for Dialysis Technician Credential".

5. A dialysis technician applicant who has completed an out-of-state dialysis technician training program shall submit evidence of:

a. Successful completion of a comprehensive, written final examination from a board-approved dialysis technician training program; or

b. Dialysis technician certification issued within the past two (2) years by the Nephrology Nursing Certification Commission, the Board of Nephrology Examiners Nursing and Technology, or the National Nephrology Certification Organization.

(2) An individual shall be exempt from the credentialing requirement while enrolled in an approved dialysis technician training program. The individual shall use the title dialysis

technician trainee.

(3) Upon approval of the application, the board shall initially issue the dialysis technician credential for twenty-four (24) months following the month of issuance. The credential shall lapse on the last day of the credentialing period.

(4)(a) An applicant for a dialysis technician credential may engage in dialysis care as a dialysis technician applicant upon:

1. Receipt by the board of the "Application for Dialysis Technician Credential"; and

2. Meeting the requirements of subsection (6) of this section.

(b) The dialysis technician applicant shall only practice dialysis care as an applicant until:

1. The credential is issued; or

2. The application is denied by the board.

(5) An "Application for Dialysis Technician Credential" submitted for initial credentialing shall be valid for six (6) months from the date of receipt by the board.

(6) A felony or misdemeanor conviction shall be reviewed to determine whether:

(a) The application shall be processed with no further action; or

(b) The application shall be processed only after:

1. The applicant has entered into an agreed order with the board with terms and conditions as agreed by the parties; or

2. If the parties are unable to agree on terms and conditions, a hearing is held pursuant to KRS 314.091 and 201 KAR 20:162, and a final decision is entered by the board.

(7) An applicant shall not be credentialed until a report is received from the FBI pursuant to the request submitted under subsection (1)(a)5 of this section and any conviction is addressed by the board.

Section 3. Renewal. (1) To be eligible for renewal of the credential, the dialysis technician shall submit, no later than one (1) month prior to the expiration date of the credential:

(a) The "Application for Renewal of the Dialysis Technician Credential"; and

(b) The fee established in Section 12 of this administrative regulation.

(2) Upon approval of the application, the credential shall be renewed for twenty-four (24) months. The credential shall lapse on the last day of the credentialing period.

(3) A dialysis technician shall report to the board at the time of renewal the name of the national certification program that has issued the technician's certification and provide a copy of the certification certificate to the board.

Section 4. Reinstatement. (1) Before beginning practice as a dialysis technician or a dialysis technician applicant, the individual shall meet the requirements of this section. If the dialysis technician credential has lapsed for a period of less than one (1) credentialing period, the individual may reinstate the credential by:

(a) Submitting the "Application for Dialysis Technician Credential";

(b) Paying the fee established in Section 12 of this administrative regulation; and

(c) Providing a criminal record check report from the Kentucky Administrative Office of the Courts, Courtnet Disposition System that is dated within six (6) months of the date of the application.

(2) If the dialysis technician credential has lapsed for more than one (1) credentialing period, the dialysis technician may reinstate the credential by:

(a) Completing a board-approved dialysis technician training program before submitting the "application for Dialysis Technician Credential". While enrolled in a training program, the individual shall be referred to as a dialysis technician trainee;

(b) Submitting the "Application for Dialysis Technician Credential";

(c) Paying the fee established in Section 12 of this administrative regulation;

(d) Submitting the "Checklist for Dialysis Technician Competency Validation" signed by the individual's immediate supervisor;

(e) Providing a criminal record check report from the Kentucky

Administrative Office of the Courts, Courtnet Disposition System that is dated within six (6) months of the date of application; and

(f) Providing a completed Federal Bureau of Investigation (FBI) Applicant Fingerprint Card and the fee required by the FBI that is dated within six (6) months of the date of the application.

(3) An "Application for Dialysis Technician Credential" submitted for reinstatement shall be valid for six (6) months from the date of receipt by the board.

(4) Upon approval of the application, the credential shall be reinstated for twenty-four (24) months following the month of issuance. The credential shall lapse on the last day of the credentialing period.

(5) An applicant shall not be credentialed until a report is received from the FBI pursuant to the request submitted under subsection (2)(f) of this section and any conviction is addressed by the board.

Section 5. Scope of Practice. (1) The scope of practice of a dialysis technician shall include the following and shall be performed under the direct, on-site supervision of a registered nurse or a physician:

(a) Preparation and cannulation of peripheral access sites (arterial-venous fistulas and arterial-venous grafts);

(b) Initiating, delivering or discontinuing dialysis care;

(c) Administration of the following medications only:

1. Heparin 1:1000 units or less concentration either to prime the pump, initiate treatment, or for administration throughout the treatment, in an amount prescribed by a physician, physician's assistant or advanced registered nurse practitioner. The dialysis technician shall not administer heparin in concentrations greater than 1:1000 units.

2. Normal saline via the dialysis machine to correct dialysis-induced hypotension based on the facility's medical protocol. Amounts beyond that established in the facility's medical protocol shall not be administered without direction from a registered nurse or a physician.

3. Intradermal lidocaine, in an amount prescribed by a physician, physician's assistant, or advanced practice registered nurse;

(d) Assistance to the registered nurse in data collection;

(e) Obtaining a blood specimen via a dialysis line or a peripheral access site;

(f) Responding to complications that arise in conjunction with dialysis care; and

(g) Performance of other acts as delegated by the registered nurse pursuant to 201 KAR 20:400.

(2) The scope of practice of a dialysis technician shall not include:

(a) Dialysis care for a patient whose condition is determined by the registered nurse to be critical, fluctuating, unstable, or unpredictable;

(b) The connection and disconnection of patients from, and the site care and catheter port preparation of, percutaneously or surgically inserted central venous catheters; and

(c) The administration of blood and blood products.

Section 6. Discipline of a Dialysis Technician. (1) A dialysis technician, an employer of dialysis technicians, or any person having knowledge of facts shall report to the board a dialysis technician who may have violated any provision of this administrative regulation.

(2) The board shall have the authority to discipline a dialysis technician for:

(a) Failure to safely and competently perform the duties of a dialysis technician as stated in Section 5 of this administrative regulation;

(b) Practicing beyond the scope of practice as stated in Section 5 of this administrative regulation;

(c) Conviction of any felony, or a misdemeanor involving drugs, alcohol, fraud, deceit, falsification of records, a breach of trust, physical harm or endangerment to others, or dishonesty under the laws of any state or of the United States. The record of conviction or a copy thereof, certified by the clerk of the court or by the judge

who presided over the conviction, shall be conclusive evidence. A "conviction" shall include pleading no contest, entering an Alford plea, or entry of a court order suspending the imposition of a criminal penalty to a crime;

(d) Obtaining or attempting to obtain a credential by fraud or deceit;

(e) Abusing controlled substances, prescription medications, or alcohol;

(f) Misuse or misappropriation of any drug placed in the custody of the dialysis technician for administration, or for use of others;

(g) Falsifying or in a negligent manner making incorrect entries or failing to make essential entries on essential records;

(h) Having a dialysis technician credential disciplined by another jurisdiction on grounds sufficient to cause a credential to be disciplined in this Commonwealth;

(i) Practicing without filing an "Application for Dialysis Technician Credential" or without holding a dialysis technician credential;

(j) Abuse of a patient;

(k) Theft of facility or patient property;

(l) Having disciplinary action on a professional or business license;

(m) Violating any lawful order or directive previously entered by the board;

(n) Violating any administrative regulation promulgated by the board;

(o) Having been listed on the nurse aide abuse registry with a substantiated finding of abuse, neglect, or misappropriation of property; or

(p) Having violated the confidentiality of information or knowledge concerning any patient, except as authorized or required by law.

(3) The discipline may include the following:

(a) Immediate temporary suspension of the credential, following the procedure set out in KRS 314.089;

(b) Reprimand of the credential;

(c) Probation of the credential for a specified period of time, with or without limitations and conditions;

(d) Suspension of the credential for a specified period of time;

(e) Permanent revocation of the credential; or

(f) Denying the application for a credential.

(4) The board shall follow the procedures set out in and have the authority set forth in KRS 314.091, 201 KAR 20:161, and 20:162 for management and resolution of complaints filed against a dialysis technician.

(5) In addition to the provisions of subsection (3) of this section, the board may impose a civil penalty of up to \$10,000.

Section 7. Dialysis Technician Training Program Standards. (1) Program administrator. A registered nurse, holding a current Kentucky license, temporary work permit, or multistate privilege, with at least one (1) year of experience in dialysis care, shall be administratively responsible for planning, development, implementation, and evaluation of the dialysis technician training program. The name, title, and credentials identifying the educational and professional qualifications of the program administrator shall be provided to the board. A change in the program administrator shall be reported to the board within thirty (30) days of the change.

(2) Faculty qualifications. The dialysis technician training program shall be taught by multidisciplinary faculty with expertise in the subject matter. The name, title, and credentials identifying the educational and professional qualifications of each didactic and clinical instructor shall be provided to the board.

(3) The dialysis technician training program shall be based upon the "Dialysis Technician Training Program Guide".

(4) The dialysis technician training program syllabus shall include:

(a) Prerequisites for admission to the program;

(b) Program outcomes. The outcomes shall provide statements of measurable competencies to be demonstrated by the learner; supportive content identified;

(d) Content. The content shall be described in outline format with corresponding time frame and testing schedules;

(e) Teaching methods. The activities of both instructor and learner shall be specified. These activities shall be congruent with stated objectives and content, and reflect application of adult learning principles;

(f) Instructional or reference materials. All required instructional reference materials shall be identified; and

(g) Evaluation. There shall be clearly defined criteria for evaluating the learner's achievement of program outcomes. There shall also be a process for annual program evaluation by trainees, program administrator, faculty, and employers.

(5) Any proposed substantive changes to the dialysis technician training program syllabus after initial submission shall be submitted to the board in writing and shall not be implemented without approval from the board.

(6) Trainee clinical practice requirements. The dialysis technician trainee enrolled in a dialysis technician training program shall practice dialysis care incidental to the training program only under the supervision of a faculty member, or his designee.

(7) The dialysis technician training program shall be at least 400 hours in length. A minimum of 200 hours shall be didactic.

(8) Completion requirements. Requirements for successful completion of the dialysis technician training program shall be clearly specified. The requirements shall include demonstration of clinical competency and successful completion of a comprehensive, written final examination. The final examination shall be administered only during the final forty (40) hours of the training program. There shall be a statement of policy regarding a trainee who fails to successfully complete the training program.

(9) The program shall establish a written records retention plan describing the location and length of time records are maintained. At a minimum, the following records shall be maintained by the program:

(a) Provider name, dates of program offerings, and sites of the training program;

(b) The program code number issued by the board; and

(c) Trainee roster, with a minimum of name, date of birth, Social Security number, and program completion date.

(10) An individual who successfully completes the training program shall receive a certificate of completion that documents the following:

(a) Name of individual;

(b) Title of training program, date of completion, and location;

(c) Provider's name;

(d) The program code number issued by the board; and

(e) Name and signature of program administrator.

(11) The program shall submit the "List of Dialysis Technician Training Program Graduates" within three (3) working days of the program completion date.

(12) The program shall notify the board in writing within thirty (30) days of a training program closure. The notification shall include the date of closing, a copy of the program trainee roster from the date of the last renewal to the date of closing, the location of the program's records as defined in subsection (9) of this section, and the name and address of the custodian of the records.

(13) A dialysis technician training program that conducts either the didactic portion or the clinical portion in this state shall be required to be approved by the board and the program shall meet the requirements of this section.

Section 8. Dialysis Technician Training Program Initial Approval. (1) To receive initial approval, a dialysis technician training program shall:

(a) File an "Application for Dialysis Technician Training Program Approval"; and

(b) Pay the fee established in Section 12 of this administrative regulation.

(2) Board approval for a dialysis technician training program that meets the requirements of this administrative regulation shall be granted for a two (2) year period from the date of approval.

(3) Upon approval, the board shall issue a program code number.

Section 9. Continued Board of Approval of a Dialysis Technician Training Program. (1) To receive continued approval, a dialysis technician training program shall:

(a) File an "Application for Dialysis Technician Training Program Approval";

(b) Submit an annual program evaluation summary report and any actions taken as a result of the evaluation as required by Section 7(4)(g) and (5) of this administrative regulation;

(c) Submit a list of current faculty including the name, title, and credential identifying the educational and professional qualifications of each instructor;

(d) Submit a copy of the program trainee roster for the past two (2) years as required by Section 7(9)(c) of this administrative regulation; and

(e) Pay the fee established in Section 12 of this administrative regulation

(2) The application shall be submitted at least two (2) months prior to the end of the current approval period.

(3) Continued approval shall be based on compliance with the standards set out in Section 7 of this administrative regulation.

(4) Continued approval shall be granted for a two (2) year period.

(5) If a program fails to maintain continued approval, the approval shall lapse.

Section 10. Reinstatement of Dialysis Technician Training Programs. A program whose approval has lapsed and that seeks to reinstate that approval shall:

(1) File an "Application for Dialysis Technician Training Program Approval"; and

(2) Pay the fee established in Section 12 of this administrative regulation.

Section 11. Board Actions on Dialysis Technician Training Programs. (1) A representative of the board may make a site visit to a dialysis technician training program to determine if the program is complying with regulatory standards.

(2) The board shall prepare a report of the site visit, identifying deficiencies for the training program, and shall include recommendations and requirements to be met in order to maintain compliance with standards.

(3) The program administrator shall submit to the board a response to the site visit report.

(4) Based on the report of deficiencies, the training program's response, and any other relevant evidence, the board may grant approval, continue approval, continue approval with stipulations as determined by the board, or propose to deny or withdraw approval of the program.

(5) A dialysis technician training program administrator may request a review of a board decision concerning approval using the following procedure:

(a) A written request for the review shall be filed with the board within thirty (30) days after the date of notification of the board action which the dialysis technician training program administrator contests.

(b) The board, or its designee, shall conduct a review. The dialysis technician training program administrator may appear in person to present reasons why the board's decision should be set aside or modified.

(c) The dialysis technician training program administrator shall be notified of the board's decision.

(6) The board shall deny or withdraw approval of a program after an administrative hearing conducted pursuant to KRS Chapter 13B.[]

Section 12. Fees. (1) The application fee for the initial credential shall be seventy (70) dollars.

(2) The credential renewal fee shall be seventy (70) dollars.

(3) The credential reinstatement fee shall be \$100.

(4) The dialysis technician training program initial approval fee shall be \$950.

(5) The dialysis technician training program continued approval fee shall be \$800.

(6) The dialysis technician training program reinstatement fee shall be \$950.

(7) An additional fee of twenty-five (25) dollars shall be charged for an application for renewal of the credential that is filed after the deadline for filing.

(8) An additional fee of \$150 shall be charged for an application for continued dialysis technician training program approval that is filed after the deadline for filing.

(9) A fee of ~~ten (10)~~^{thirty-five (35)} dollars shall be charged for issuing a duplicate of the credential.

(10) A check submitted to the board for payment of a fee which is returned by the bank for nonpayment shall be assessed a return check fee of thirty-five (35) dollars.

(11) A fee of ten (10) dollars shall be charged for written verification of a dialysis technician credential. If submitted in list format, a fee of ten (10) dollars for the first name shall be assessed and a fee of one (1) dollar shall be assessed for each additional name.

(12) A fee of twenty-five (25) dollars shall be charged for a duplicate application form which is issued due to the failure to maintain a current mailing address as required by Section 13 of this administrative regulation.

(13) A fee of thirty five (35) dollars shall be charged for a name change and the issuance of a new credential.

(14) All fees shall be nonrefundable.

Section 13. Miscellaneous Requirements. (1) Any person credentialed by the board as a dialysis technician shall maintain a current mailing address with the board and immediately notify the board in writing of a change of mailing address.

(2) As a condition of holding a credential from the board, a dialysis technician shall be deemed to have consented to service of notices or orders of the board at the mailing address on file with the board. Any notice or order of the board mailed or delivered to the mailing address on file with the board shall constitute valid service of the notice or order.

(3) Any dialysis technician credentialed by the board shall, within ninety (90) days of entry of the final judgment, notify the board in writing of any misdemeanor or felony conviction in this or any other jurisdiction. A conviction shall include pleading no contest, entering an Alford plea, or entry of a court order suspending the imposition of a criminal penalty to a crime. Upon learning of any failure to notify the board under this provision, the board may initiate an action for immediate temporary suspension until the person submits the required notification.

(4) Any dialysis technician credentialed by the board shall immediately notify the board in writing if any professional or business license that is issued to the person by any agency of the commonwealth or any other jurisdiction is surrendered or terminated under threat of disciplinary action or is refused, limited, suspended, or revoked, or if renewal of continuance is denied.

(5) If the board has reasonable cause to believe that any dialysis technician is unable to practice with reasonable skill and safety or has abused alcohol or drugs, it may require the person to submit to a chemical dependency evaluation or a mental or physical examination by a practitioner it designates. Upon failure of the person to submit to a chemical dependency evaluation or a mental or physical examination, unless due to circumstances beyond the person's control, the board may initiate an action for immediate temporary suspension pursuant to KRS 314.089 or deny an application until the person submits to the required examination.

(6) Every dialysis technician shall be deemed to have given consent to submit to a chemical dependency evaluation or a mental or physical examination when so directed in writing by the board. The direction to submit to an evaluation or an examination shall contain the basis of the board's reasonable cause to believe that the person is unable to practice with reasonable skill and safety, or has abused alcohol or drugs. The person shall be deemed to have waived all objections to the admissibility of the examining practitioner's testimony or examination reports on the ground of privileged communication.

(7) The dialysis technician shall bear the cost of any chemical

dependency evaluation or mental or physical examination ordered by the board.

Section 14. Incorporation by Reference. (1) The following materials are incorporated by reference:

(a) "Application for Dialysis Technician Training Program Approval", Kentucky Board of Nursing, 6/06;

(b) "Application for Dialysis Technician Credential", Kentucky Board of Nursing, 12/09;

(c) "Application for Renewal of Dialysis Technician Credential", Kentucky Board of Nursing, 9/07;

(d) "Checklist for Dialysis Technician Competency Validation", Kentucky Board of Nursing, 9/07;

(e) "Dialysis Technician Training Program Guide", August 14, 2001, Kentucky Board of Nursing; and

(f) "List of Dialysis Technician Training Program Graduates", Kentucky Board of Nursing, 9/07.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222-5172, Monday through Friday, 8 a.m. to 4:30 p.m.

SALLY BAXTER, President

APPROVED BY AGENCY: December 13, 2013

FILED WITH LRC: January 10, 2014 at 9 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 26, 2014 at 10:00 a.m. (EST) in the office of the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by February 19, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Nathan Goldman, General Counsel, Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, phone (502) 429-3309, fax (502) 564-4251, email nathan.goldman@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Nathan Goldman

(1) Provide a brief summary of:

(a) What this administrative regulation does: It sets standards and requirements for dialysis technician credentialing and training programs.

(b) The necessity of this administrative regulation: It is required by statute.

(c) How this administrative regulation conforms to the content of the authorizing statutes: By setting standards and requirements.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By setting standards and requirements.

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

(a) How the amendment will change this existing administrative regulation: It lowers the fee for issuing a duplicate credential from thirty-five (35) to ten (10) dollars.

(b) The necessity of the amendment to this administrative regulation: The Dialysis Technician Advisory Council requested the change.

(c) How the amendment conforms to the content of the authorizing statutes: The Board is authorized to set fees.

(d) How the amendment will assist in the effective administration of the statutes: By setting the fee.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: dialysis technicians, currently there are 506.

(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 amendment does not impose any new actions that applicants would be required to do. If a dialysis technician would need a duplicate credential, they would have to pay the new, lower fee.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The new fee is ten (10) dollars.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be in compliance with the regulation.

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

(a) Initially: There is no additional cost.

(b) On a continuing basis: There is no additional cost.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Agency 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 is needed.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: It does not.

(9) TIERING: Is tiering applied? Tiering was not applied as the changes apply to all equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Board of Nursing.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 314.131.

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No additional cost.

(d) How much will it cost to administer this program for subsequent years? No additional cost.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

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

301 KAR 1:155. Commercial fishing requirements.

RELATES TO: KRS 150.010, 150.120, 150.170, 150.175, 150.445, 150.450(2), (3), 150.990, 217.015(20)

STATUTORY AUTHORITY: KRS 150.025(1), 150.175(3), 50 C.F.R. 17

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish seasons for the taking of fish and wildlife, to regulate bag limits, creel limits, and methods of take, and to make these requirements apply to a limited area. KRS 150.175(3) authorizes the department to establish a commercial fishing license that allows the taking and selling of rough fish. 50 C.F.R. Part 17 protects the shovelnose sturgeon from harvest because of similarity of appearance with the endangered pallid sturgeon. This administrative regulation establishes commercial fishing requirements, protects certain species from overharvest, and regulates the buying and selling of roe-bearing species of rough fish.

Section 1. Definitions. (1) "Buyer's permit" means a Roe-bearing Fish Buyer's Permit.

(2) "Commercial fisherman" means a person holding a valid resident or nonresident commercial fishing license.

(3) "Harvester permit" means a Roe-bearing Fish Harvester's Permit.

(4) "Immediate family member" means a person's spouse, mother, father, daughter, brother, sister, grandparent, or son.

(5) "Ohio River Trophy Catfish Harvest Permit" means a permit which allows a commercial fisherman to participate in a special catfish harvest program downstream of Cannelton Lock and Dam in the Ohio River and its tributaries open to commercial fishing.

(6) "Overflow lake" means a permanent or temporary body of water that receives overflow flood waters from an adjacent stream.

(7) [(6)] "Roe-bearing fish" means paddlefish, shovelnose sturgeon, and bowfin, regardless of the sex of the fish or the presence or absence of roe.

(8) [(7)] "Roe-bearing Fish Buyer's Permit" means a permit issued by the Department of Fish and Wildlife Resources that entitles the permittee to buy roe-bearing species or roe in accordance with this administrative regulation.

(9) [(8)] "Roe-bearing Fish Harvester's Permit" means a permit issued by the Department of Fish and Wildlife Resources to a licensed commercial fisherman that entitles the permit holder to harvest and sell roe-bearing species in accordance with this administrative regulation.

(10) [(9)] "Sport fish" means those species so designated by 301 KAR 1:060.

(11) "Trophy catfish" means a:

(a) Blue or flathead catfish that is a minimum of forty (40) inches in length; or

(b) Channel catfish that is a minimum of thirty (30) inches in length.

(12) [(10)] "Unlicensed helper" means a person without a commercial fishing license who is assisting a commercial fisherman.

(13) [(11)] "Unprocessed roe" means roe that has been removed from a roe-bearing fish by a food-processing plant prior to its sale at a roe-bearing fish buyer's facility.

Section 2. Nonresident Commercial Fishing Licenses. A nonresident commercial fishing license shall only be issued to residents of states that offer nonresident fishing licenses to Kentucky residents, except that a nonresident with a valid 2013 Kentucky nonresident commercial fishing license shall be eligible to purchase a nonresident fishing license in subsequent license years unless the nonresident fails to purchase the permit during any license year.

Section 3. Unlicensed Helpers. (1) A commercial fisherman shall not utilize more than two (2) unlicensed helpers while actively fishing.

(2) A commercial fisherman shall ensure that an unlicensed helper complies with all boating safety requirements established in KRS Chapter 235.

(3) An unlicensed helper shall:

(a) Be accompanied by a licensed commercial fisherman while using commercial fishing gear; and

(b) Be permitted to transport roe or roe-bearing fish in the absence of a commercial fisherman with a Fish Transportation Permit as established in 301 KAR 1:125.

(4) A commercial fisherman whose commercial fishing license has been suspended or revoked in Kentucky or in another state shall not:

(a) Be listed as a helper by a licensed Kentucky commercial fisherman; or

(b) Assist a licensed Kentucky commercial fisherman in harvesting or transporting fish.

Section 4.[3-] Tagging and Using Commercial Gear. A commercial fisherman shall:

(1) Tag commercial fishing gear pursuant to 301 KAR 1:146;

(2) Not use commercial fishing gear within:

(a) Fifty (50) yards of the outlet or inlet of an overflow lake; or

(b) Fifty (50) yards of the mouth of a stream except the mouth of the Ohio River; and

(c) 200 yards of a dam, as established in KRS 150.445;

(3) Not use commercial nets from April 1 through October 31:

(a) In bays and inlets of Kentucky or Barkley Lakes; or

(b) Within a distance of 200 yards from the mouth of bays or inlets in Kentucky or Barkley Lakes; and

(4) Call the department at 800-858-1549 within twenty-four (24) hours if any commercial gear is:

(a) Lost;

(b) Stolen; or

(c) ~~Irretrievable~~[Unretrievable] due to unforeseen circumstances.

Section 5. Special Catfish Harvest Restrictions. (1) In the Ohio River and its tributaries open to commercial fishing:

(a) There shall be an unlimited harvest of:

1. Blue and flathead catfish that are less than thirty-five (35) inches in length; and

2. Channel catfish that are less than twenty-eight (28) inches in length; and

(b) There shall be a daily limit of one (1):

1. Blue and flathead catfish greater than thirty-five (35) inches in length; and

2. Channel catfish greater than twenty-eight (28) inches in length.

(2) A person with a valid commercial license shall obtain from the department a free Ohio River Trophy Catfish Harvest Permit in order to harvest multiple trophy catfish downstream of Cannelton Lock and Dam.

(a) The department shall issue a maximum of fifty (50) permits annually.

(b) Beginning in 2015, the department shall issue a permit to a commercial fisherman who:

1. Has reported a minimum harvest of 10,000 pounds of catfish from the Ohio River and its tributaries open to commercial fishing in at least two (2) of the last three (3) years; and

2. Sends a written request to the department postmarked on or before March 10.

(c) In 2014, the department shall issue a permit to a commercial fisherman who:

1. Has reported a minimum harvest of 10,000 pounds of catfish from the Ohio River or its tributaries open to commercial fishing in at least two (2) of the last three (3) years; and

2. Sends a written request to the department postmarked on or before ten (10) days following the effective date of this administrative regulation.

(d) There shall be an unlimited daily harvest of catfish less than

trophy size for each permit holder.

(e) There shall be a daily harvest limit of four (4) trophy catfish in aggregate for each permit holder.

(f) Beginning in 2015, if fifty (50) permits are not issued by March 15, then the department shall conduct a random electronic lottery drawing for the remaining slots.

(g) A commercial fisherman shall apply for the lottery established in paragraph (f) of this subsection by sending a written request to the department to be entered in the lottery postmarked on or before March 10.

(h) In 2014, if fifty (50) permits are not issued within fifteen (15) days following the effective date of this administrative regulation, then the department shall conduct a random electronic lottery drawing for the remaining slots.

(i) A commercial fisherman shall apply for the lottery established in paragraph (h) of this subsection by sending a written request to the department to be entered in the lottery postmarked on or before ten (10) days following the effective date of this administrative regulation.

(j) If the number of applicants for any lottery is less than the number of available permits, then the remaining permits shall be distributed on a first-come first-serve basis.

Section 6.[4-] Roe-bearing Fish Harvester's Permit. (1) In order to retain his or her permit privilege, a Roe-bearing Fish Permit holder shall submit to the department the following by September 15:

(a) A completed Application for Roe-bearing Fish Harvester's Permit; and

(b) The permit fee as established in 301 KAR 3:022.

(2) A mailed application and fee shall be postmarked on or before September 15.

(3) Prior to being issued a harvester permit, a person shall possess a valid commercial fishing license.

(4) A harvester permit shall not be sold to a resident of a state that will not sell a nonresident harvester permit, or its equivalent, to Kentucky residents.

(5) The maximum number of resident Roe-bearing Fish Harvester's Permits available each year shall be 101.

(6) The maximum number of nonresident Roe-bearing Permits available each year shall be eighteen (18).

(7) A harvester permit holder shall be eligible to transfer permit privileges to:

(a) An immediate family member; or

(b) An unlicensed helper who:

1. Has been employed by the permit holder for a period of at least one (1) year in that capacity; and

2. Complies with the requirements of this administrative regulation.

(8) To transfer a permit, the permit holder shall send to the department:

(a) A notarized letter documenting the name and relationship of the permit recipient; and

(b) If an unlicensed helper, proof of employment of the unlicensed helper for a period of one (1) year.

(9) Transferability shall be voided if a commercial fishing license or harvester permit is revoked or suspended as established in Section 12 of this administrative regulation.

Section 7.[5-] Roe-bearing Fish Harvester Permit Lottery. (1) There shall be a lottery for the unfilled harvester permits below the quota.

(2) A person shall apply for the lottery by submitting the following to the department by September 15:

(a) A completed Roe-bearing Fish Harvester Permit Application; and

(b) The appropriate permit fee as established in 301 KAR 3:022.

(3) A mailed application shall be postmarked by September 15 to be eligible.

(4) A person chosen in the lottery shall first obtain a commercial fishing license prior to obtaining a harvester permit.

(5) The department shall return all permit fees to those not

chosen in the lottery.

(6) If the department receives fewer resident or nonresident harvester permit applications than the number of available permits, then completed applications received after September 15 shall be filled in the order they were received until the quota has been reached.

(7) If the number of permit applications received on a day after September 15 exceeds the number of permits available, then a second lottery shall be held to determine the recipients of the available permits.

Section 8.[6-] Fish Harvester Permit Requirements. (1) A harvester permit shall be required for a licensed commercial fisherman to harvest, transport, or sell roe fish or unprocessed roe.

(2) A permit shall not be required for a special commercial fishing permit holder to harvest and sell roe-bearing fish flesh or unprocessed roe from Kentucky and Barkley lakes during the special commercial fishing season, as established in 301 KAR 1:140.

(3) A harvester permit shall not be issued unless all applicable reports have been completed and submitted to the department, pursuant to Section 12 of this administrative regulation.

(4) A harvester permit holder shall:

(a) Have the permit in possession while:

1. Fishing for roe-bearing fish; and
2. Transporting or selling roe-bearing fish or unprocessed roe;

(b) Only sell, ship, barter, or provide harvested roe from roe-bearing fish to a Kentucky permitted buyer as established in Section 7 of this administrative regulation; and

(c) Possess a valid bill of lading if transporting unprocessed roe to a Kentucky permitted buyer.

Section 9.[7-] Buyer's Permit Requirements. (1) A buyer's permit shall be required to buy, sell, barter, receive, or ship unprocessed roe from roe-bearing fish harvested in Kentucky.

(2) A person shall apply for a buyer's permit by submitting a completed Application for Commercial Roe-bearing Fish Buyer's Permit along with the appropriate permit fee to the department, as established in 301 KAR 3:022.

(3) A buyer's permit holder shall:

(a) Not knowingly purchase illegally taken fish or unprocessed roe from any state;

(b) Have in possession a valid buyer's permit while purchasing, receiving, or transporting unprocessed roe;

(c) Maintain for a period of three (3) years an accurate record of all unprocessed roe purchased from roe fish harvesters in Kentucky;

(d) Maintain for a period of three (3) years an accurate record of all unprocessed roe purchased from roe fish harvesters in another state including:

1. Name, address, and telephone number of the seller;
2. License number of the seller; and
3. Number of pounds of unprocessed roe purchased;

(e) Sign the harvester permit holder's Daily Roe-bearing Fish Harvester's Transaction Report for each transaction prior to purchasing or receiving unprocessed roe from the harvester;

(f) Retain a copy of the Daily Roe-bearing Fish Harvester's Transaction Report for each transaction with a harvester permit holder for a period of three (3) years; and

(g) Allow a conservation officer access to all records and reports, as established in this section, upon request, during normal business hours.

Section 10.[8-] Commercial Fishing Season and Size Limits.

(1) The commercial fishing season shall be open year round in the waters listed in 301 KAR 1:150 except for:

(a) Kentucky and Barkley lakes as described in 301 KAR 1:140;

(b) The shovelnose sturgeon season, which shall extend from October 15 through May 15 in the Ohio River Basin only; and

(c) The paddlefish season which shall extend from:

1. November 1 through April 30 in all waters open to commercial fishing, except Barkley and Kentucky Lakes, as

specified in 301 KAR 1:140; and

2. November 1 through May 31 for commercial trotlines in all waters open to commercial fishing, except the Ohio and Mississippi Rivers.

(2) There shall not be a size limit on any commercially-harvested rough fish, except that a commercial fisherman shall only harvest:

(a) Shovelnose sturgeon between twenty-four (24) and thirty-two (32) inches, as measured from the tip of snout to the fork of the tail fin; and

(b) Paddlefish that are thirty-two (32) inches or greater, as measured from the beginning of the eye to the fork of the tail fin, except for Kentucky and Barkley lakes as specified in 301 KAR 1:140.

(3) A harvester or buyer permit holder shall not possess:

(a) Unprocessed Paddlefish roe after June 5:[6-]

(b) Unprocessed Shovelnose sturgeon roe after May 20; or

(c) Blue catfish, flathead catfish, and channel catfish as established in Section 5 of this administrative regulation, and measured by laying the fish flat on a ruler with the mouth closed and tail lobes squeezed together.

Section 11.[9-] Species Ineligible for Commercial Harvest. (1) A commercial fisherman shall not harvest, and shall immediately release the following species:

(a) Sport fish listed in 301 KAR 1:060;

(b) Pallid sturgeon, a federally-endangered species;

(c) Lake sturgeon;

(d) Shovelnose sturgeon caught in the Mississippi River; and

(e) All turtle species.

(2) A licensed commercial fisherman shall only sell roe-bearing fish or unprocessed roe from roe-bearing fish harvested by commercial fishing methods established in and permitted by 301 KAR 1:146.

Section 12.[10-] Tending Gear and Removing Fish. A commercial fisherman shall:

(1) Tend and remove the fish from:

(a) Hoop nets or slat traps at least once every seventy-two (72) hours; and

(b) Other commercial fishing gear at least once every twenty-four (24) hours;

(2) Not possess eggs of any species of fish outside of the fish's body cavity while on the water or adjacent bank; and

(3) Remove commercial fishing gear from the water when finished fishing.

Section 13.[11-] Roe Fish Egg Checking Methodology. A commercial fisherman shall use a ten (10) gauge or smaller needle to examine roe fish for the presence of eggs.

Section 14.[12-] Reporting, License and Permit Suspension, Renewal, and Revocation. (1) Every licensed commercial fisherman shall submit a completed Monthly Report of Commercial Fish Harvest in Kentucky by the tenth day of every month for the previous month's harvest even if no harvest occurred.

(2) A harvester permit holder shall:

(a) Complete a Daily Roe-bearing Fish Harvester's Report for each day of the month that roe-bearing fish are harvested or sold to a Kentucky permitted buyer; and

(b) Submit to the department all completed daily reports within a calendar month by the tenth day of the following month in addition to the reporting requirements established in subsection (1) of this section.

(3) If a buyer's permit holder completes any transactions in a given month, the permit holder shall submit to the department a completed Monthly Commercial Roe-bearing Fish Buyer's Report by the tenth day of the following month.

(4) A report that is being mailed to the department shall be postmarked on or before the tenth of the month pursuant to subsections (1) through (3) of this section.

(5) The department shall issue a courtesy reminder letter to a holder of a commercial fishing license, harvester permit, or buyer's

permit who has failed to submit to the department a monthly report by the deadlines established in subsections (1) through (4) of this section.

(6) The department shall issue a warning letter to a license or permit holder who has twice failed to meet the reporting deadlines established in subsections (1) through (4) of this section during any given commercial fishing license year.

(7) The department shall suspend the commercial fishing license of a license or permit holder who has failed to meet reporting deadlines for three (3) or more months in a given license year until the license or permit holder submits to the department all required reports.

(8) The department shall suspend for a period of three (3) months the commercial fishing license of a license holder who has not met the reporting deadlines established in this section for four (4) or more times in a license year.

(9) If a three (3) month suspension extends into a new license year, subsequent delinquent reports shall result in additional three (3) month suspensions.

(10) The department shall not renew a commercial fishing license, harvester permit, or buyer's permit for a person who has not satisfied the reporting requirements of this administrative regulation.

(11) The department shall revoke the commercial fishing license, for a period of two (2) years, of a person who has been convicted of a federal commercial fishing violation or the following state violations involving commercial fishing:

(a) Use of illegal commercial fishing gear, pursuant to 301 KAR 1:146;

(b) Knowingly placing commercial fishing gear in a restricted area, pursuant to Section 3(2) and 3(3) of this administrative regulation;

(c) Harvesting prohibited species of fish;

(d) Commercially fishing in waters not open to commercial fishing, pursuant to 301 KAR 1:150; or

(e) Knowingly falsifying commercial harvest data.

(12) The department shall revoke a buyer's permit, for a period of two (2) years, of a person:

(a) Convicted of federal commercial fishing violation; or

(b) Who falsified data on a Monthly Commercial Roe-bearing Fish Buyer's Report.

(13) A person may request an administrative hearing pursuant to KRS Chapter 13B if a permit has been:

(a) Denied;

(b) Suspended;

(c) Not renewed; or

(d) Revoked.

Section 15,[13.] Boundaries. The department shall make available on its Web site at fw.ky.gov the Global Positioning System coordinates detailing the Kentucky and Ohio border on the Ohio River, for download to personal devices.

Section 16,[14.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Application for Commercial Roe-bearing Fish Harvester's Permit", 2008;

(b) "Application for Commercial Roe-bearing Fish Buyer's Permit", 2008;

(c) "Daily Roe-bearing Fish Harvester's Transaction Report", 2008;

(d) "Monthly Commercial Roe-Bearing Fish Buyer's Report", 2008;

(e) "Monthly Report of Commercial Fish Harvest in Kentucky", 2014[2008]; and

(f) "List of GPS coordinates for Ohio River Boundary with Ohio", 2008.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Fish and Wildlife Resources, #1 Sportsman's Lane, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

MATT SAWYERS, Acting Commissioner

ROBERT H. STEWART, Secretary

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014, 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 five (5) business days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation by February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman's Lane, Frankfort, Kentucky 40601, phone (502) 564-7109, ext. 4507, fax (502) 564-9136, email fwpubliccomments@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Rose Mack

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes commercial fishing requirements, protects certain species from overharvest, and regulates the buying and selling of roe-bearing species of rough fish.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to effectively manage rough fish 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 to establish seasons for the taking of fish and wildlife, to regulation bag limits, creel limits, and methods of take, and to make these requirements apply to a limited area. KRS 150.175(3) authorizes the department to establish a commercial fishing license that allows the taking and selling of rough fish. 50 C.F.R. 17 protects the shovelnose sturgeon from harvest in the Mississippi River because of similarity of appearance with the federally protected pallid sturgeon.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will carry out the purposes of the statutes and federal regulation by defining the requirements for commercial fishing 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 restricts the daily commercial harvest for blue and flathead catfish over 35 inches and channel catfish over 28 inches to one fish of each species in the Ohio River and its tributaries open to commercial fishing. It also establishes a minimum size limit and an aggregate daily harvest limit on trophy catfish caught downstream of Cannelton Lock and Dam. It further creates an Ohio River Trophy Catfish Harvest Permit for harvest of trophy catfish downstream of Cannelton Lock and Dam, limits the number of permits to 50, and establishes minimum catfish harvest requirements in order for a commercial fisherman to qualify for a permit. In the event that the 50 permit quota is not reached, the amendment further creates a random electronic lottery for issuing the remaining permits. The amendment will also update and modify a commercial fishing harvest report form incorporated by reference, and limit the sale of nonresident commercial fishing licenses to only residents of states that allow Kentucky residents to purchase a nonresident commercial fishing license. Nonresidents who currently hold a valid Kentucky Commercial Fishing License

who would be affected by this change will be grandfathered until they do not renew their commercial license in a license year.

(b) The necessity of the amendment to this administrative regulation: A significant sport fishery for trophy catfish has evolved on the Ohio River and has created an allocation issue of these fish between the sport and commercial anglers that harvest the same resource. This amendment is needed to reduce harvest of trophy-sized catfish in the Ohio River. A recent, decreasing trend in the ratio of trophy catfish may be evidence of overharvest of larger catfish in the Ohio River above Cannelton Lock and Dam and its tributaries open to commercial fishing. Additionally, by limiting the number Quality Catfish Harvest Permits, this Department is lowering the probability that many commercial fishermen will move their fishing effort from above Cannelton Lock and Dam to below it. The reciprocal non-resident license amendment is needed to promote in-kind commercial regulations that Kentucky residents (anglers and commercial fishermen) believe is fair. The additional information required on the Monthly Harvest Reports is necessary to increase the Department's knowledge of harvest demographics which are important to managing Kentucky's catfish fisheries open to commercial fishing.

(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: These amendments will affect all of the 293 licensed commercial fishermen at variable but unknown levels.

(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 commercial fisherman will be required to limit their harvest of trophy and quality-sized catfish, to report the number of catfish harvested, the number of trophy catfish harvested and released, and record the pool fished if fishing in the Ohio River and its tributaries open to commercial fishing. A nonresident commercial fisherman residing in a state that does not offer nonresident commercial licenses to Kentucky residents will be required to annually renew their licenses in order to continue to qualify for nonresident licenses.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Individual commercial fishermen will be economically affected at various levels which will be determined by the level of income derived from trophy catfish harvest. Typically, relatively few trophy catfish are harvested by established commercial fishermen selling to fish processors. Commercial fishermen targeting trophy catfish for pay lakes will be affected at a higher level, but these anglers do not typically rely solely on fishing for their income.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Commercial fishermen will benefit since a larger number of trophy catfish will survive and reproduce.

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

(a) Initially: This regulation amendment will not result in increased costs to the department.

(b) On a continuing basis: There will be no additional cost on a continuing basis to the department.

(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: 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: No fees will be directly or indirectly established.

(9) TIERING: Is tiering applied? Tiering is applied to this amendment because nonresidents residing in states that do not allow Kentucky residents to purchase a nonresident commercial fishing license will not be able to purchase a Kentucky nonresident commercial license if they are a first time purchaser or if they allowed their license to lapse.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Department of Fish and Wildlife Resources Divisions of Fisheries 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 authorizes the department to set seasons, establish bag or creel limits, and to regulate the buying, selling, or transporting of fish and wildlife. KRS 150.175(3) authorizes the establishment of a commercial fishing license that allows the taking and selling of rough fish. 50 C.F.R. 17 protects the shovelnose sturgeon from harvest in the Mississippi River because of similarity of appearance with the federally protected pallid sturgeon.

(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? Revenue will not be 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? Revenue will not be generated by this administrative regulation during subsequent years.

(c) How much will it cost to administer this program for the first year? No additional cost will be incurred for the first year as the Department's Law Enforcement Division already enforces the regulation.

(d) How much will it cost to administer this program for subsequent years? No additional cost will be 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:

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

301 KAR 2:172. Deer hunting seasons, zones, and requirements.

RELATES TO: KRS 150.010, 150.177, 150.180, 150.411(3), 150.990, 237.110

STATUTORY AUTHORITY: KRS 150.025(1), 150.170, 150.175, 150.390(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to establish hunting seasons, bag limits, methods of taking, and to promulgate administrative regulations establishing hunting seasons, bag limits of taking wildlife. KRS 150.170 exempts certain people from hunting license and permit requirements. KRS 150.175 authorizes the kinds of licenses and permits to be issued by the department. KRS 150.390(1) prohibits the taking of deer in any manner contrary

to any provisions of KRS Chapter 150 or its administrative regulations. This administrative regulation establishes deer hunting seasons and zones, legal methods of taking, and checking and recording requirements for deer hunting.

Section 1. Definitions. (1) "Additional deer permit" means a permit that allows the holder to take up to two (2) additional deer beyond those allowed by the statewide permit in the following combinations:

- (a) One (1) antlered deer and one (1) antlerless deer; or
- (b) Two (2) antlerless deer.

(2) "Adult" means a person who is at least eighteen (18) years of age.

(3) "Antlered deer" means a male or female deer with a visible antler protruding above the hairline.

(4) "Antlerless deer" means a male or female deer with no visible antler protruding above the hairline~~], and includes:~~

- ~~(a) Female deer; and~~
- ~~(b) Male fawns or button bucks].~~

(5) "Archery equipment" means a long bow, recurve bow, or compound bow incapable of holding an arrow at full or partial draw without aid from the archer.

(6) "Arrow" means the projectile fired from a bow or crossbow.

(7) "Barbed broadhead" means a point or portion of a blade projecting backward from a broadhead designed to hold an arrow within an animal.

(8) "Crossbow" means a bow designed or fitted with a device to hold an arrow at full or partial draw without aid from the archer.

(9) "Deer" means a member of the species *Odocoileus virginianus*.

(10) "Firearm" means a breech or muzzle-loading rifle, shotgun, or handgun.

(11) "Fully-automatic firearm" means a firearm that fires more than one (1) time with a single pull of the trigger.

(12) "License year" means the period from March 1 through the following last day of February.

(13) "Modern gun" means a rifle, handgun, or shotgun that is loaded from the rear of the barrel.

(14) "Muzzle-loading gun" means a rifle, shotgun, or handgun that is loaded from the discharging end of the barrel or discharging end of the cylinder.

(15) "Shotshell" means ammunition containing more than one (1) projectile.

(16) "Statewide deer permit" means a permit, which, in conjunction with appropriate licenses, seasons, and methods, allows the holder to take:

- (a) One (1) antlered deer and one (1) antlerless deer; or
- (b) Two (2) antlerless deer

(17) "Statewide deer requirements" means the season dates, zone descriptions, bag limits, and other requirements and restrictions for deer hunting established in this administrative regulation.

(18) "Youth" means a person under the age of sixteen (16) by the date of the hunt.

(19) "Zone" means an area consisting of counties designated by the department within which deer hunting season dates and limits are set for the management and conservation of deer in Kentucky.

Section 2. License and Deer Permit Requirements. (1) Unless exempted by KRS 150.170, a person shall carry proof of purchase of a valid Kentucky hunting license and valid deer permit while hunting.

(2) In lieu of a license or permit that grants statewide deer hunting privileges~~[permit]~~, a person possessing a valid junior statewide hunting license shall not use more than two (2) junior deer hunting permits.

(3) An additional deer permit shall not be valid unless accompanied by a valid Kentucky hunting license and a license or permit that grants statewide deer hunting privileges~~[permit]~~.

Section 3. Hunter Restrictions. (1) A deer hunter:

- (a) Shall not take deer except during daylight hours;

- (b) Shall not use dogs, except leashed tracking dogs to recover wounded deer;

- (c) Shall not take a deer that is swimming; and

- (d) Shall not take a deer from a vehicle, boat, or on horseback, except that a hunter with a disabled hunting exemption permit issued by the department may use a stationary vehicle as a hunting platform.

- (e) Shall not possess or use a decoy or call powered by electricity from any source.

(2) A deer hunter shall not take a deer with any device except a firearm, crossbow, or archery equipment as authorized by Section 5 of this administrative regulation.

(3) A person shall not use any of the following items to take a deer:

- (a) Rimfire ammunition;

- (b) A fully-automatic firearm;

- (c) A firearm with a magazine capacity greater than ten (10) rounds;

- (d) Full metal jacketed ammunition;

- (e) Tracer bullet ammunition;

- (f) A shotshell containing more than one (1) projectile~~[larger than number two (2) size shot]~~;

- (g) An arrow or crossbow bolt without a broadhead;

- (h) A broadhead smaller than seven-eighths (7/8) inch wide;

- ~~(i) [(H)]~~ A barbed broadhead;

- ~~(j) [(H)]~~ A crossbow without a working safety device;

- ~~(k) [(H)]~~ A chemically-treated arrow;

- ~~(l) [(K)]~~ An arrow with a chemical attachment;

- ~~(m) [(H)]~~ Multiple projectile ammunition; or

- ~~(n) [(M)]~~ Any weapon that is not consistent with the appropriate season established in Section 5 of this administrative regulation.

Section 4. Hunter Orange Clothing Requirements. (1) During the modern gun deer season, muzzle-loader season and any youth firearm season, a person hunting any species during daylight hours and any person accompanying a hunter, shall display solid, unbroken hunter orange visible from all sides on the head, back, and chest except while hunting waterfowl.

(2) During an elk firearm season as established in 301 KAR 2:132, a person hunting any species and any person accompanying a hunter within the elk restoration zone, shall display solid, unbroken hunter orange visible from all sides on the head, back, and chest except while hunting waterfowl.

(3) The hunter orange portions of a garment worn to fulfill the requirements of this section:

- (a) May display a small section of another color; and

- (b) Shall not have mesh weave openings exceeding one-fourth (1/4) inch by any measurement.

(4) A camouflage-pattern hunter orange garment worn without additional solid hunter orange on the head, back and chest shall not meet the requirements of this section.

Section 5. Statewide Season Dates. (1) A deer hunter may use archery equipment to hunt deer statewide from the first Saturday in September through the third Monday in January.

(2) A deer hunter may take deer with a modern firearm statewide beginning the second Saturday in November:

- (a) For sixteen (16) consecutive days in Zones 1 and 2; and

- (b) For ten (10) consecutive days in Zones 3 and 4.

(3) A deer hunter may use a muzzle-loading gun to hunt deer statewide:

- (a) For two (2) consecutive days beginning the third Saturday in October;

- (b) For nine (9) consecutive days beginning the second Saturday in December; and

- (c) During any season when a modern gun may be used to take deer.

- (4) A deer hunter may use a crossbow to hunt deer statewide:

- (a) From October 1 through the end of the third full weekend in October;

- (b) From the second Saturday in November through December 31; and

- (c) During any season when a firearm may be used to take

deer.

(5) Youth firearm season. For two (2) consecutive days beginning on the second Saturday in October, a youth deer hunter shall:

(a) Use any legal method to take antlered or antlerless deer; and

(b) Be required to follow all other statewide deer hunting requirements.

(6) There shall be a free youth weekend for two (2) consecutive days beginning on the Saturday after Christmas during which a youth shall:

(a) Not be required to have a hunting license or deer permit;

(b) Use any legal method to take antlered or antlerless deer; and

(c) Be required to follow all other statewide deer hunting requirements.

Section 6. Zones. (1) Zone 1 shall consist of Anderson, Ballard, Boone, Bracken, Caldwell, Calloway, Campbell, Carlisle, Carroll, Christian, Crittenden, Franklin, Fulton, Gallatin, Grant, Graves, Harrison, Henry, Hickman, Jefferson, Kenton, Livingston, Lyon, Marshall, McCracken, Oldham, Owen, Pendleton, Robertson, Scott, Shelby, Spencer, Trigg, Trimble, Washington, and Woodford Counties.

(2) Zone 2 shall consist of Allen, Bourbon, Boyd, Bullitt, Carter, Fayette, Fleming, Green, Greenup, Hardin, Hart, Henderson, Hopkins, Jessamine, Larue, Lawrence, Lewis, Logan, Mason, McLean, Mercer, Muhlenberg, Nelson, Nicholas, Todd, Union, and Webster Counties.

(3) Zone 3 shall consist of Adair, Barren, Bath, Boyle, Breckinridge, Butler, Casey, Clark, Cumberland, Daviess, Edmondson, Elliott, Estill, Grayson, Hancock, Johnson, Lincoln, Madison, Marion, Meade, ~~Menifee~~, Metcalf, Monroe, Montgomery, Morgan, Ohio, Powell, Rowan, Simpson, Taylor, Warren, and Wolfe Counties.

(4) Zone 4 shall consist of Bell, Breathitt, Clay, Clinton, Floyd, Garrard, Harlan, Jackson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, McCreary, ~~Menifee~~, Owsley, Perry, Pike, Pulaski, Rockcastle, Russell, Wayne, and Whitley Counties.

Section 7. Season and Zone Limits. (1) A person shall not take more than four (4) deer statewide in a license year except:

(a) As authorized in 301 KAR 2:111, 2:176, 2:178, and 3:100; and

(b) A person may take an unlimited number of antlerless deer in Zone 1 provided the person has purchased the appropriate additional deer ~~bonus~~ permits.

(2) A person shall not take more than one (1) antlered deer per license year, regardless of the permit type used, except as established in 301 KAR 2:111, 2:178, and 3:100.

(3) In Zone 3, a person may take two (2) deer with a firearm.

(4) In Zone 4, a person may take:

(a) Only two (2) deer with a firearm; and

(b) Only antlered deer ~~only~~ during:

1. Modern firearm season;

2. Early muzzleloader season; and

3. The first six (6) days of the December muzzleloader season.

(5) The aggregate bag limit for Zones, 2, 3, and 4 shall be four (4) deer per hunter.

Section 8. Supervision of Youth Firearm Deer Hunters. (1) An adult shall:

(a) Accompany a person under sixteen (16) years old; and

(b) Remain in a position to take immediate control of the youth's firearm.

(2) An adult accompanying a youth hunter shall not be required to possess a hunting license or deer permit if the adult is not hunting.

Section 9. Harvest Recording. (1) Immediately after taking a deer, and prior to moving the carcass, a person shall record, in writing:

(a) The species taken:

(b) The date taken:

(c) The county where taken; and

(d) The sex of the deer taken on one (1) of the following:

1. The hunter's log section on the reverse side of a license or permit;

2. The hunter's log produced in a hunting guide;

3. A hunter's log printed from the Internet;

4. A hunter's log available from any KDSS agent; or

5. An index or similar card.

(2) The person shall retain and possess the completed hunter's log when the person is in the field during the current hunting season.

Section 10. Checking a Deer. (1) A person shall check a harvested deer by:

(a) Calling the toll free telecheck number at (800) 245-4263 or on the department's Web site ~~website~~ at fw.ky.gov:

1. Before midnight on the day the deer is recovered; and

2. Prior to processing or removing the hide or head from the carcass;

(b) Providing the information requested by the automated check-in system; and

(c) Writing the confirmation number given by the system on the hunter's log authorized in Section 9 of this administrative regulation.

(2) If a hunter transfers possession of a harvested deer, the hunter shall attach to the carcass a hand-made tag that contains the following information:

(a) The confirmation number;

(b) The hunter's name; and

(c) The hunter's telephone number.

(3) A person shall not provide false information while completing the hunter's log, checking a deer, or creating a carcass tag.

Section 11. Transporting and Processing Deer. (1) A person shall:

(a) Not transport an unchecked deer out of Kentucky;

(b) Have proof that a deer or parts of deer brought into Kentucky were legally taken;

(c) Not sell deer hides except to a licensed:

1. Fur buyer;

2. Fur processor; or

3. Taxidermist.

(2) A taxidermist or an individual who commercially butchers deer shall:

(a) not accept deer carcasses or any part of a deer without a valid disposal permit issued by the department pursuant to KRS 150.411(3) or a proper carcass tag as established in Section 10 of this administrative regulation.

(3) An individual who commercially butchers deer shall ~~(b)~~ keep accurate records of the hunter's name, address, confirmation number, and date received for each deer in possession and retain such records for a period of one (1) year.

MATT SAWYERS, Acting Commissioner

ROBERT H. STEWART, Secretary

APPROVED BY AGENCY: January 10, 2014

FILED WITH LRC: January 14, 2014 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014, at 10 a.m. at the Department of Fish and Wildlife Resources in the Commission Room of the Arnold L. Mitchell Building, #1 Sportsman's Way, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing five (5) 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 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 attend the public hearing, you may submit written comments on

the proposed administrative regulation by February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman's Lane, Frankfort, Kentucky 40601, phone (502) 564-7109, ext. 4507, fax (502) 564-9136, email fwpubliccomments@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Rose Mack

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes deer hunting seasons and zones, methods of taking, bag limits, harvest recording procedures, and checking requirements.

(b) The necessity of this administrative regulation: To allow for safe and effective harvest and related record-keeping for the long-term conservation and management of deer populations.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 150.025 authorizes the department to promulgate administrative regulations establishing hunting seasons, bag limits, and the methods to take wildlife. KRS 150.170 exempts certain people from hunting license and permit requirements. KRS 150.175 authorizes the kinds of licenses and permits that are issued by the department. KRS 150.390 prohibits the taking of deer in any manner contrary to any provisions of Chapter 150 or its regulations.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the statutes by establishing the seasons, limits, procedures, and requirements authorized by the statutes.

(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 Menifee County to a more restrictive zone in response to hunter complaints, clarifies that female deer that have antlers are considered antlered deer, and bucks that have shed their antlers are considered antlerless deer for harvest regulation purposes, and removes language regarding records requirements for taxidermists that conflict with KRS 150.411.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to restrict doe harvest in Menifee County and clarify existing elements of the regulation.

(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 deer hunters must comply with the requirements, seasons and limits in this 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:

(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: Hunters in Menifee County will have to abide by the harvest restrictions for Zone 4. Hunters who harvest a female with antlers must treat it as an antlered deer regarding harvest restrictions, while those who take a male deer that has naturally shed its antlers must treat it as an antlerless deer.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There will be no additional cost to hunters as a result of this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Reduction of doe harvest in Menifee County by moving it to a Zone 4 should improve deer numbers and thus hunter satisfaction over time.

(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 a fee or funding to implement this administrative regulation.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No new fees will be established.

(9) TIERING: Is tiering applied? Tiering was not used because all deer hunters are subject to the same seasons, bag limits, and zone requirements for hunting.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 150.025(1), 150.170, 150.175 and 150.390(1).

(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? Direct revenue from the sale of all deer permits is estimated to be between \$3.5 and \$4.0 million based on recent years' sales.

(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? Revenue during subsequent years is dependent on the number of permits sold, which has been stable to slightly decreasing in recent 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 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:

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

301 KAR 2:178. Deer hunting on Wildlife Management Areas, state parks, other public lands, and federally controlled areas.

RELATES TO: KRS 150.010, 150.170, 150.340, 150.370(1), 150.990

STATUTORY AUTHORITY: 148.029(5), 150.025(1), 150.390(1), 150.620

NECESSITY, FUNCTION, AND CONFORMITY: KRS 148.029(5) authorizes the Department of Parks, in cooperation with

the Department of Fish and Wildlife Resources, to implement wildlife management plans on state parks. KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish open seasons for the taking of wildlife, to regulate bag limits, and to make these requirements apply to a limited area. KRS 150.390(1) prohibits the taking of deer in any manner contrary to any provisions of KRS Chapter 150 or its administrative regulations. KRS 150.620 authorizes the department to promulgate administrative regulations for the maintenance and operation of the lands it has acquired for public recreation. This administrative regulation establishes deer hunting seasons, application procedures, and other matters pertaining to deer hunting on Wildlife Management Areas, state parks, other public lands, and federally controlled areas that differ from statewide requirements.

Section 1. Definitions. (1) "Bait" means a substance composed of grains, minerals, salt, fruits, vegetables, hay, or any other food materials, whether natural or manufactured, that may lure, entice, or attract wildlife.

(2) "Centerfire" means a type of firearm that detonates a cartridge by the firing pin striking a primer in the middle of the end of the cartridge casing.

(3) "In-line muzzleloading gun" means a firearm capable of being loaded only from the discharging end of the barrel or cylinder, that is also equipped with an enclosed ignition system located directly behind the powder charge.

(4) "Mobility-impaired" means an individual who meets the requirements of [Section 2(1) of] 301 KAR 3:026, Section 2(1).

(5) "Modern firearm season" means the ten (10) or sixteen (16) consecutive day period beginning the second Saturday in November when breech-loading firearms may be used to take deer pursuant to 301 KAR 2:172.

(6) "Quota hunt" means a hunt where a participant is selected by a random drawing.

(7) "Statewide requirements" mean the season dates, zone descriptions, and other requirements for deer hunting established in 301 KAR 2:172.

(8) "Wildlife management area" or "WMA" means a tract of land:

(a) Controlled by the department through ownership, lease, license, or cooperative agreement; and

(b) That has "Wildlife Management Area" or "WMA" as part of its official name.

(9) "Youth" means a person under the age of sixteen (16) by the date of the hunt.

Section 2. General WMA Requirements. (1) Unless specified in this administrative regulation, statewide requirements shall apply.

(2) A hunter shall not take more than one (1) deer per day on a WMA in Zones 2, 3, or 4, except:

(a) During a quota hunt; or

(b) The Grayson Lake WMA open youth deer hunt.

(3) Unless specified in Section 6 of this administrative regulation, if a WMA is in two (2) or more deer hunting zones as established in 301 KAR 2:172, then the WMA shall be regulated by the most liberal zone requirements of the zones in which it lies.

(4) Deer hunting on WMAs listed in Section 6 of this administrative regulation shall be permitted only as stated, except archery hunting is allowed under the statewide archery requirements established in 301 KAR 2:172, unless otherwise noted.

(5) An antlerless deer shall not count against a person's statewide or zone bag limit if harvested during:

(a) The Grayson Lake WMA open youth hunt;

(b) West Kentucky WMA firearms hunts; or

(c) Any WMA either-sex quota hunt.

(6) An open firearm deer hunt, beginning on the Wednesday following the third Monday in January for ten (10) consecutive days, shall:

(a) Be limited to members of the United States Armed Forces and the National Guard and reserve component who:

1. Are residents of Kentucky or nonresidents stationed in Kentucky; and

2. Were deployed out-of-country during any portion of the most recent regular statewide deer season.

(b) Only be on a WMA designated as open for this special hunt; and

(c) Follow statewide requirements established in 301 KAR 2:172.

~~(7) [(6)]~~ On all WMAs and Otter Creek Outdoor Recreation Area, a person:

(a) Shall not use a nail, spike, screw-in device, wire, or tree climber for attaching a tree stand or climbing a tree;

(b) May use a portable stand or climbing device that does not injure a tree;

(c) Shall not place a portable stand in a tree more than two (2) weeks before opening day, and shall remove it within one (1) week following the last day, of each hunting period;

(d) Shall plainly mark the portable stand with the hunter's name and address;

(e) Shall not use an existing permanent tree stand; and

(f) Shall not place, distribute, or hunt over bait.

~~(8) [(7)]~~ A person without a valid quota hunt confirmation number shall not enter a WMA during a quota hunt on that area except:

(a) To travel through a WMA on an established road or to use an area designated open by a sign; or

(b) One (1) assistant, who shall not be required to have applied for the quota hunt, may accompany a mobility-impaired hunter who was drawn to hunt.

~~(9) [(8)]~~ Except for waterfowl or dove hunting, or legal hunting at night, a person who is hunting any species or a person who is accompanying a hunter, shall wear hunter orange clothing pursuant to 301 KAR 2:172 while:

(a) On a WMA when firearms deer hunting is allowed;

(b) Hunting within the sixteen (16) county elk zone when a firearms elk season is open, pursuant to 301 KAR 2:132; or

(c) Hunting within the bear zone during a bear firearms season, pursuant to 301 KAR 2:300.

Section 3. General Quota Hunt Procedures. (1) A quota hunt applicant who is not selected and applies to hunt the following year shall be given one (1) preference point for each year the applicant was not selected.

(2) If selected for a quota hunt, a person shall lose all accumulated preference points.

(3) A random selection of hunters with preference points shall be made for each year's quota hunts before those without preference points are chosen.

(4) A person shall forfeit all accumulated preference points if, in a given year, the person does not apply for or is ineligible to apply for:

(a) A deer quota hunt; and

(b) The no-hunt option.

(5) A person who applies for the no-hunt option shall:

(a) Not be drawn for a quota hunt; and

(b) Be given one (1) preference point for each year the no-hunt option is selected.

(6) If applying as a party:

(a) Each applicant's preference points are independent of each other; and

(b) The entire party is selected if one (1) member of the party is selected.

(7) The commissioner may extend the application deadline if technical difficulties with the automated application system prevent applications from being accepted for one (1) or more days during the application period.

(8) A hunter may take up to two (2) deer on a quota hunt in Zones 2, 3, and 4, only one (1) of which may be an antlered deer, except as authorized in Section 6 of this administrative regulation.

(9) Provided a person has purchased the appropriate permits, a hunter may take unlimited antlerless deer in:

(a) The West Kentucky WMA firearms season;

(b) WMA quota hunts in Zone 1; and

(c) State Park quota hunts in Zone 1, except as specified in section 7 of this administrative regulation.

(10) One (1) person shall be drawn from the eligible quota hunt applicants who were not selected in the original drawing, and shall receive one (1) deer permit that carries with it all the privileges of the Special Commission Permit described in 301 KAR 3:100.

Section 4. Quota Hunt Application Process. A person applying for a quota hunt shall:

(1) Call the toll free number listed in the current fall hunting and trapping guide or apply online at fw.ky.gov between September 1 and September 30;

(2) Enter each applicant's Social Security number;

(3) Select:

(a) A first and second choice of hunts; or

(b) The no-hunt option.

(4) Pay a three (3) dollar application fee for each applicant, prior to the draw by:

(a) Electronic funds transfer;

(b) Visa Card;

(c) Master Card; or

(d) Discover Card;

(5) Not apply more than one (1) time;

(6) Not apply as a group of more than five (5) persons; and

(7) Not be eligible to participate in a quota hunt unless selected pursuant to this administrative regulation, or accompanying a mobility-impaired hunter.

Section 5. Quota Hunt Participant Requirements. Except as otherwise specified in this administrative regulation, a person selected to participate in a quota hunt shall:

(1) Except if exempted by KRS 150.170, possess:

(a) A valid annual Kentucky hunting license; and

(b) A deer permit that authorizes the taking of deer with the equipment being used and in accordance with the zone restrictions where the hunt will occur;

~~(2) Possess an additional deer permit if the person does not want a harvested antlerless deer to apply toward the statewide bag limit, pursuant to 301 KAR 2:172; (3) Hunt on the assigned dates and in assigned areas selected by a random drawing of applicants if applicable;~~

~~(3) (4) Comply with hunting equipment restrictions specified by the type of hunt;~~

~~(4) (5) Check in at the designated check station prior to hunting;~~

(a) Either:

1. On the day before the hunt, between noon and 8 p.m. local time; or

2. On the day of the hunt, between 5:30 a.m. and 8 p.m. Eastern time; and

(b) With documentation of the participant's:

1. Social Security number or draw confirmation number; and

2. Purchase of a current license or permit which allows or includes statewide deer hunting privileges~~[permit]~~;

~~(5) (6) Check out at the designated check station:~~

(a) If finished hunting;

(b) If the hunter's bag limit is reached; or

(c) By 8 p.m. Eastern time on the final day of the hunt;

~~(6) (7) Take a harvested deer to the designated check station by 8 p.m. Eastern time the day the deer was harvested.~~

~~(7) (8) Be declared ineligible to apply for the next year's drawing if the hunter fails to check out properly; and~~

~~(8) (9) Comply with all species quota hunt requirements, including the fifteen (15) inch minimum outside antler spread harvest restriction for antlered deer when in effect, or be ineligible to apply for any quota hunt or no-hunt option for these species the following year.~~

Section 6. Wildlife Management Area Requirements. (1) Dr. Norman and Martha Adair WMA. The crossbow season shall be open under statewide requirements.

(2) Ballard WMA.

(a) On the main tract, the quota hunt shall be for two (2) consecutive days beginning on the first Saturday in November.

(b) On the main tract, the archery, crossbow, and youth firearm

seasons shall be open under statewide requirements through October 14, except that the two (2) mile driving loop marked by signs shall be closed to all hunting;

(c) The crossbow, modern firearm, youth firearm, and muzzleloader seasons shall be open under statewide requirements only on the 400 acre tract south of Sallie Crice Road.

(d) A hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.

(3) Barren River WMA. The area shall be open under statewide requirements except that on the Peninsula Unit, including Narrows, Goose and Grass Islands, a person shall not hunt deer with a modern firearm.

(4) Beaver Creek WMA.

(a) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.

(b) The limit shall be one (1) antlered deer during the quota hunt.

(c) The crossbow season shall be open under statewide requirements.

(5) Big Rivers WMA.

(a) The crossbow and youth firearms seasons shall be open under statewide requirements; and

(b) There shall be a quota hunt for two (2) consecutive days beginning the ~~first~~second Saturday in November.

(6) Boatwright WMA. The area shall be open under statewide requirements, except that:

(a) On the Swan Lake Unit the archery and crossbow season shall be open under statewide requirements through October 14; and

(b) The October youth deer season shall be open under statewide requirements.

(7) Cedar Creek Lake WMA. The crossbow season shall be open under statewide requirements.

(8) Clay WMA.

(a) On the main tract, crossbow, October muzzleloader, and youth firearm seasons shall be open under statewide requirements, except archery hunting shall be prohibited during the quota fox hunting field trials as established in 301 KAR 2:049.

(b) The remainder of the WMA shall be open under statewide requirements for the archery, crossbow, October muzzleloader, and youth seasons, except during the quota deer hunt.

(c) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.

(d) A quota hunt participant shall be given one (1) preference point for each female deer checked-in.

(e) Hunters drawn for the quota hunt may harvest up to four (4) deer, only one (1) of which may be antlered.

(9) Dewey Lake WMA.

(a) The crossbow and youth firearm seasons shall be open under statewide requirements.

(b) The use of firearms shall be prohibited for deer hunting on the portion of the area extending southward from the dam to Shoreline Campground Number One, and including all property from the WMA boundary downslope to the lake edge.

(c) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.

(d) There shall be a quota hunt for two (2) consecutive days beginning the first Saturday in December.

(e) There shall be a one (1) deer limit during the quota hunt.

(10) Dix River WMA. The crossbow, youth firearm, and muzzleloader seasons shall be open under statewide requirements.

(11) Fishtrap Lake WMA.

(a) The quota hunt shall be for two (2) consecutive days beginning on the Saturday before Thanksgiving.

(b) The limit for the quota hunt shall be one (1) deer.

(c) The crossbow and youth firearm season shall be open under statewide requirements.

(12) Grayson Lake WMA.

(a) An open youth hunt shall:

1. Be the first Saturday in November for two (2) consecutive days; and

2. Have a two (2) deer bag limit, only one (1) of which may be

an antlered deer[; and

~~3. Have additional deer permits apply].~~

(b) A person who has not checked in shall not enter the Grayson Lake WMA during the open youth hunt, except to:

1. Travel through the WMA on an established public road; or
2. Use an area designated as open by signs.

(c) The property of Camp Webb shall be open for a mobility-impaired deer hunting event during the first weekend of October as established in 301 KAR 3:110.

(d) The crossbow hunt shall be from the first Saturday in September through the third Monday in January, except during the November open youth hunt.

(e) The statewide youth firearm season shall be open under statewide requirements.

(13) Green River Lake WMA and Dennis-Gray WMA.

(a) The crossbow season shall be open under statewide requirements.

(b) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.

(c) Fifteen (15) openings shall be reserved in the quota hunt for mobility-impaired persons.

(d) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.

(e) The Green River Lake and Dennis-Gray WMAs shall be considered to be located in the Eastern Time Zone.

(14) Griffith Woods WMA. The crossbow and youth firearms seasons shall be open under statewide requirements.

(15) Higginson-Henry WMA.

(a) The youth firearm deer season shall be open under statewide requirements.

(b) A hunter shall not take more than one (1) deer from the WMA per license year.

(16) J.C. Williams WMA. The crossbow and youth firearm seasons~~[season]~~ shall be open under statewide requirements.

(17) Kentucky River WMA. The crossbow and youth firearm seasons shall be open under statewide requirements.

(18) Kleber WMA.

(a) The crossbow season shall be open under statewide requirements, except during a quota hunt.

(b) The quota hunts shall be for:

1. Two (2) consecutive days beginning the first Saturday in November; and
2. Two (2) consecutive days beginning the first Saturday in December.

(c) The youth firearm season shall be open under statewide requirements.

(19) Knobs State Forest WMA. The crossbow season shall be open under statewide requirements.

(20) Lake Barkley WMA shall be open under statewide requirements except

(a) The North Refuge is closed from November 1 to February 15; and

(b) Duck Island is closed from October 15 to March 15.

(21) Lewis County WMA.

(a) The modern firearm and youth firearm seasons shall be open under statewide requirements, except the use of centerfire rifles and handguns shall be prohibited.

(b) The crossbow and muzzleloader seasons shall be open under statewide requirements.

(22) Livingston County WMA. The crossbow, youth firearm, muzzleloader, and modern firearm seasons shall be open under statewide requirements, except a person shall not hunt deer with a modern gun during the modern firearm deer season.

(23) Curtis Gates Lloyd WMA. The crossbow and youth firearms seasons~~[season]~~ shall be open under statewide requirements.

(24) Marion County WMA.

(a) The crossbow, muzzleloader, and youth firearm seasons shall be open under statewide requirements.

(b) There shall be a quota hunt for:

1. Five (5) consecutive days beginning the second Saturday in November; and
2. Five (5) consecutive days beginning the Thursday following

the second Saturday in November.

(c) A quota hunt participant shall not be required to check in and out of the WMA, but shall telecheck or internet-check harvested deer as specified in 301 KAR 2:172.

(25) Mill Creek WMA.

(a) The crossbow season shall be open under statewide requirements.

(b) The quota hunt shall:

1. Be for two (2) consecutive days beginning the first Saturday in November; and

2. Have a one (1) deer bag limit.

(26) Miller-Welch Central Kentucky WMA. The archery and crossbow seasons shall be open under statewide requirements:

(a) On Monday through Thursday, from the first Saturday in September through December 17, except during scheduled field trials as posted on the area bulletin board; and

(b) December 18 through the third Monday in January.

(27) Mud Camp Creek WMA. The crossbow, youth firearm, and muzzleloader seasons shall be open under statewide requirements.

(28) Mullins WMA. The crossbow season shall be open under statewide deer requirements.

(29) Ohio River Islands WMA, Stewart Island Unit.

(a) The muzzleloader season shall be for two (2) consecutive days beginning the third Saturday in October.

(b) The archery season shall be from the first Saturday in September through October 14.

(c) The crossbow season shall be from October 1 through October 14.

(d) The October youth season shall be open under statewide requirements.

(e) The remainder of the WMA shall be open under statewide requirements.

(30) Paintsville Lake WMA.

(a) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.

(b) The crossbow and youth firearm seasons shall be open under statewide requirements.

(c) A person shall not use firearms for deer hunting on:

1. The area extending eastward from the drainage of Glade Branch, along the north edge of the lake, to the No Hunting Area surrounding Rocky Knob Recreation Area and enclosing all property from the WMA boundary downslope to the lake edge; and

2. The islands to the south and that portion of the area extending eastward along the south edge of the lake from the drainage of Shoal Branch to the No Hunting Area surrounding the dam and ranger station, and extending downslope to the edge of the lake.

(d) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.

(31) Peabody WMA.

(a) The crossbow, youth firearms, and muzzleloader seasons shall be open under statewide requirements.

(b) The modern firearm season shall be open under statewide requirements for ten (10) consecutive days beginning the second Saturday in November.

(32) Pennyryle State Forest-Tradewater WMA.

(a) The crossbow season shall be open under statewide requirements.

(b) The quota hunt shall be for two (2) consecutive days beginning the first Saturday in November.

(c) A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.

(33) Pioneer Weapons WMA. Statewide requirements shall apply except that a person:

(a) Shall not use a modern firearm;

(b) Shall not use an in-line muzzleloading gun;

(c) Shall not use a scope;

(d) May use a crossbow during the entire archery season; and

(e) Shall use only open or iron sights on any weapon.

(34) Redbird WMA. The crossbow season shall be open under statewide requirements.

(35) Dr. James R. Rich WMA.

(a) The crossbow season shall be open under statewide requirements, except during a quota hunt.

(b) The quota hunts shall be for:

1. Two (2) consecutive days beginning the first Saturday in November; and

2. Two (2) consecutive days beginning the first Saturday in December; and

(c) The youth firearm season shall be open under statewide requirements.

(36) Robinson Forest WMA.

(a) A person shall not hunt deer on the main block of Robinson Forest.

(b) The remainder of the WMA shall be open under statewide requirements.

(37) Sloughs WMA.

(a) On the Sauerheber Unit, the archery, crossbow, muzzleloader, and youth firearm seasons shall be open under statewide requirements through October 31, except that the Crenshaw and Duncan II Tracts shall be open under statewide requirements through the end of modern firearm season.

(b) The remainder of the WMA shall be open under statewide requirements.

(38) South Shore WMA.

(a) The youth firearm, October muzzleloader, and modern firearm seasons shall be open under statewide requirements through November 14, except that the use of centerfire rifles and handguns shall be prohibited.

(b) The archery and crossbow seasons shall be open under statewide requirements, except the area shall be closed November 15 through January 15.

(39) T.N. Sullivan WMA. The crossbow season shall be open under statewide requirements.

(40) R.F. Tarter WMA. The crossbow, youth firearm, and muzzleloader seasons shall be open under statewide requirements.

(41) Taylorsville Lake WMA.

(a) There shall be a quota hunt for:

1. Two (2) consecutive days beginning the first Saturday in November for antlerless deer;

2. Two (2) consecutive days beginning the first Saturday in December; and

3. Two (2) consecutive days beginning the first Saturday in January.

(b) Seven (7) openings shall be reserved in each quota hunt for mobility-impaired persons.

(c) The youth firearm season shall be open under statewide requirements.

(d) The crossbow season shall be open under statewide requirements.

(e) A[quota hunt] participant in the November antlerless-only quota hunt shall be given one (1) preference point for each female deer checked in, up to four (4).

(42) Twin Eagle WMA. The crossbow season shall be open under statewide requirements.

(43) Paul Van Booven WMA. The crossbow season[area] shall be open under statewide requirements[~~except that a hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches~~].

(44) Veteran's Memorial WMA.

(a) The crossbow and youth firearms seasons shall be open under statewide requirements; and

(b) There shall be a quota hunt for two (2) consecutive days beginning the first Saturday in November.

(45) West Kentucky WMA.

(a) All tracts shall be open under statewide requirements for the archery and crossbow seasons, except that all tracts shall be closed to archery and crossbow hunting during department administered quota and firearm deer hunts.

(b) Tracts 1-6 shall be open to shotgun and muzzleloader hunters participating in the quota and open firearm deer hunts.

(c) Tract 7 and "A" Tracts shall not be open for department administered quota or firearm deer hunts.

(d) The quota hunt shall be for five (5) consecutive days

beginning the Saturday prior to Thanksgiving.

(e) The firearms season shall:

1. Be for three (3) consecutive days beginning the Saturday preceding the third Monday in January;

2. Be limited to the first 200 hunters;

3. Require a hunter to check-in at a designated check station from 4 p.m. to 8 p.m. Central Time on the day before the hunt or between 4:30 a.m. and 7 p.m. Central Time on hunt days;

4. Shall require a hunter to check out at the designated check station:

a. When finished hunting; or

b. By 7 p.m. Central time on the final day of the hunt.

5. Have an unlimited bag limit, only one (1) of which may be an antlered deer; and

~~6. Have additional deer permits apply; and~~

~~7.]~~ Require every person to check in during the firearms season, except for:

a. A person traveling on an established public road; or

b. A person in an area designated as open by signs.

(f) Firearm hunters shall not use centerfire rifles or handguns;

(g) All persons shall check in daily at the designated check-in locations before entering the "A" tracts.

(h) A deer hunter shall not take a deer with antlers that have an outside spread of less than fifteen (15) inches.

(i) A participant in the quota hunt or open firearms season[hunter] shall:

1. Sign in for the hunting tract of his or her choice at check-in prior to each day's hunt; and

2. Except after noon, not hunt outside of that tract.

(46) Yatesville WMA. The crossbow, youth firearm, muzzleloader, and modern firearm seasons shall be open under statewide requirements, except a person shall not take antlerless deer with a firearm during the modern firearm deer season.

(47) Yellowbank WMA. ~~[(a)]~~ The crossbow and youth firearm deer seasons shall be open under statewide requirements. ~~[(b)]~~ A deer hunter shall not take a deer with antlers that have an outside spread less than fifteen (15) inches.]

Section 7. State Park Deer Seasons. (1) A state park may allow archery and crossbow hunting from the first Saturday in September through the third Monday in January for antlered or antlerless deer.

(2) A state park may allow up to sixteen (16) days of firearm hunting and up to eleven (11) days of muzzleloader hunting from the first Saturday in September through the third Monday in January for antlered or antlerless deer.

(3) The following state parks shall be open to deer hunting as specified below and according to requirements in Section 8 of this administrative regulation:

(a) Lake Barkley State Resort Park. Deer hunting shall be permitted on the first Tuesday of January for two (2) consecutive days.

(b) Greenbo Lake State Resort Park. Deer hunting shall be permitted on the first Tuesday of January for two (2) consecutive days.

(c) Green River Lake State Park.

1. Archery and crossbow deer hunting shall be permitted beginning the second Thursday of December for four (4) consecutive days.

2. Archery and crossbow deer hunting shall be permitted beginning the third Thursday of December for four (4) consecutive days.

3. A deer hunter shall not take an antlered deer with antlers having an outside spread less than fifteen (15) inches.

(d) Yatesville Lake State Park. Muzzleloading firearm, archery, and crossbow deer hunting shall be permitted under statewide deer requirements on the third Monday of December for three (3) consecutive days.

(e) Jenny Wiley State Resort Park.

1. Deer hunting shall be permitted on the first Saturday of January for two (2) consecutive days.

2. The bag limit shall be two (2) deer, only one (1) of which may be antlered.

3. The hunt shall be open to the first fifteen (15) mobility-impaired persons who check in at the park on the day before the hunt.

4. A person who participates in the hunt shall comply with the requirements established in 301 KAR 3:026.

5. A deer hunter shall not take an antlered deer with antlers having an outside spread less than fifteen (15) inches.

Section 8. State Park Deer Hunt Requirements. (1) Except for the open hunts at Jenny Wiley State Resort Park and Yatesville Lake State Park, a person shall not hunt on a state park unless:

(a) Selected by a random drawing as described in Section 3 of this administrative regulation;

(b) The person is a member of a successful applicant's hunting party; or

(c) The person was selected as part of a process administered by the Department of Parks, pursuant to Section 7 of this administrative regulation.

(2) A person participating in a state park hunt, except for the quota hunts at Green River Lake State Park and the Yatesville Lake State Park open deer hunt, shall:

(a) Check in and check out as required in Section 5 of this administrative regulation;

(b) Furnish at check-in a driver's license or other form of government-issued identification; and

(c) Check in:

1. Between noon and 8 p.m. Eastern Time the day before the hunt at the state park campground if hunting in the Yatesville Lake State Park open deer hunt; or

2. At the park the day before the hunt if hunting in the Jenny Wiley State Resort Park deer hunt; and

(d) Not be eligible to apply for a quota hunt the following year if the person does not check out as required in Section 5 of this administrative regulation.

(3) A person participating in a state park deer hunt shall:

(a) Comply with the provisions of 301 KAR 2:172; and

(b) Check harvested deer daily at the designated park check station, except that deer taken in the Green River Lake State Park quota hunts and the open hunts at Jenny Wiley State Resort Park and Yatesville Lake State Park shall be telechecked or checked in on the department's website at fw.ky.gov, pursuant to 301 KAR 2:172.

(4) A person participating in a state park deer hunt shall not:

(a) Take more than two (2) deer in a quota hunt, only one (1) of which may be antlered;

(b) Hunt over bait;

(c) Injure a tree by using:

1. A tree stand except a portable stand;

2. Climbing devices that nail or screw to the tree; or

3. Climbing spikes;

(d) Leave a deer stand unattended for more than twenty-four (24) hours;

(e) Discharge a firearm within 100 yards of a maintained road or building; and

(f) Hunt:

1. In an area posted as closed by signs; or

2. Outside park boundaries.

(5) A person participating in a state park deer hunt, other than the open hunts at Jenny Wiley State Resort Park and Yatesville Lake State Park and any department administered state park quota hunt, may take up to two (2) bonus deer per hunt that shall not count toward the statewide limit if the person:

(a) Takes no more than one (1) bonus antlered deer per license year; and

(b) Obtains the valid bonus deer tag(s) from the state park hunt administrators.

Section 9. Other Public Lands. (1) On Daniel Boone National Forest, Jefferson National Forest and Land Between the Lakes, a person shall not use bait, feed, minerals, or other attractants.

(2) The following areas may schedule a firearm, crossbow, or archery deer hunting season between September 1 and January 31:

(a) Big South Fork National River and Recreation Area;

(b) Clark's River National Wildlife Refuge;

(c) Daniel Boone National Forest;

(d) Jefferson National Forest;

(e) Land Between the Lakes National Recreation Area;

(f) Ohio River Islands National Wildlife Refuge; and

(g) Reelfoot National Wildlife Refuge.

(3) An area listed in subsection (2) of this section may issue a bonus permit for antlered or antlerless deer which shall:

(a) Not count against a hunter's statewide bag limit; and

(b) Only be issued for a hunt that is open to the general public.

(4) At Land Between the Lakes, a person:

(a) Shall not take more than:

1. Two (2) deer during archery hunts; and

2. One (1) deer during quota hunts.

(b) Who is a quota deer hunter shall:

1. Apply in advance at Land Between the Lakes; and

2. Only hunt from one-half (1/2) hour before sunrise until one-half (1/2) hour after sunset.

(c) A person who harvests a deer shall:

1. Check in the carcass pursuant to U.S. Forest Service requirements.

2. Affix a game check card pursuant to U.S. Forest Service requirements.

(5) At Reelfoot National Wildlife Refuge:

(a) Zone 1 bag limits apply during the open archery season;

(b) A person shall not take more than two (2) deer by firearm, only one (1) of which shall be antlered;

(c) A quota hunt participant shall:

1. Tag deer with a tag issued by the Refuge; and

2. Comply with the Refuge check-in requirements; and

(d) A person who is archery hunting shall:

1. Only take deer using the appropriate statewide or additional deer permit; and

2. Check harvested deer through the department's telephone or online check-in systems.

(6) At Otter Creek Outdoor Recreation Area:

(a) The archery and crossbow seasons shall be open under statewide requirements; and

(b) There shall be a quota hunt for:

1. Two (2) consecutive days beginning the third Saturday in November; and

2. Two (2) consecutive days beginning the second Saturday in December.

(7) At Twin Knobs Campground, the area shall be closed to all statewide seasons, except that there shall be a quota hunt on the second Saturday in December during odd-numbered years for mobility-impaired persons.

(8) At Zilpo Campground, the area shall be closed to all statewide seasons, except that there shall be a quota hunt on the second Saturday in December during even-numbered years for mobility-impaired persons.

Section 10. Special Areas under Federal Control. (1) The following areas may schedule a firearm, archery, or crossbow deer hunting season between September 1 and January 31:

(a) Bluegrass Army Depot;

(b) Fort Campbell;

(c) Fort Knox;

(d) Hidden Valley Training Center; and

(e) Wendell Ford Regional Training Center.

(2) An area listed in subsection (1) of this section may issue a bonus permit for antlered or antlerless deer which shall:

(a) Not count against a hunter's statewide bag limit; and

(b) Only be issued for a hunt that is open to the general public.

(3) Except on the Hidden Valley Training area, on the areas listed in subsection (1) of this section, a deer hunter shall:

(a) Obtain a permit from the area before hunting;

(b) Only hunt on assigned dates;

(c) Remain in assigned areas;

(d) Tag deer with tags issued on the area, unless otherwise specified in this section;

(e) Keep the area tag attached to the deer until the carcass is

processed; and

(f) Check deer at a designated check station before leaving the area.

(4) At Bluegrass Army Depot, a person shall not take an antlered deer whose outside antler spread is less than fifteen (15) inches.

(5) At Fort Knox, a person shall not take an antlered deer whose outside antler spread is less than twelve (12) inches.

(6) At Hidden Valley Training Area, a person shall not use a firearm to hunt deer.

MATT SAWYERS, Acting Commissioner

ROBERT H. STEWART, Secretary

APPROVED BY AGENCY: January 10, 2014

FILED WITH LRC: January 14, 2014 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on 11 a.m. at February 21, 2014, at the Department of Fish and Wildlife Resources in the Commission Room of the Arnold L. Mitchell Building, #1 Sportsman's Lane, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing five (5) business days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation by February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Rose Mack, Department of Fish and Wildlife Resources, Arnold L. Mitchell Building, #1 Sportsman's Lane, Frankfort, Kentucky 40601, phone (502) 564-7109, ext. 4507, fax (502) 564-9136, email: 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 the deer hunting seasons, limits, and equipment restrictions under which deer may be taken on wildlife management areas, state parks, and other lands controlled by state or federal government agencies.

(b) The necessity of this administrative regulation: To establish deer hunting seasons, limits, and methods of taking deer to control and manage deer populations and hunting pressure on wildlife management areas, state parks, and other public lands.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 150.025(1) authorizes the Department of Fish and Wildlife Resources to promulgate administrative regulations governing hunting seasons, including deer. KRS 150.390(1) prohibits the taking of deer in any manner contrary to any provisions of KRS Chapter 150 or its administrative regulations. KRS 150.620 authorizes the department to manage public lands for hunting and fishing.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the administration of the statute by establishing guidelines for effectively managing deer herds on Wildlife Management Areas (WMAs), state parks, and other public lands, including the establishment of guidelines to ensure safe, orderly hunting practices on public lands.

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

(a) How the amendment will change this existing administrative regulation: This amendment modifies the deer hunting requirements and restrictions for 7 Wildlife Management Areas (Curtis Gates Lloyd, J.C. Williams, Dewey Lake, Beaver Creek, Big Rivers, Paul Van Booven, and Yellowbank).

(b) The necessity of the amendment to this administrative

regulation: This amendment is necessary to maximize hunter opportunity without harm to the deer resource.

(c) How the amendment conforms to the content of the authorizing statutes: See (1)(c) above.

(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: Hunters who wish to deer hunt on certain public lands, WMAs and state parks in Kentucky will be affected. In 2013, there were approximately 9,000 total quota hunt applications for approximately 4,000 available slots; these numbers are expected to remain the about same or slightly increase for the 2014-15 season (due to the acquisition of additional WMA acreage).

(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: Those who hunt deer on WMAs and state parks must comply with the individual hunt requirements for those sites, as listed in the fall hunting guide produced by the department.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There will be no direct cost to hunters as a result of this amendment to the administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Deer hunters will benefit from increased hunting opportunity on several public lands.

(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 agency to implement this regulation.

(b) On a continuing basis: There will be no additional cost on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: 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 a fee or 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 or increase any fees.

(9) TIERING: Is tiering applied? Tiering was not used because all persons who hunt deer on WMAs, state parks, or other public lands are required to abide by these guidelines.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 148.029(5), 150.025(1), 150.390(1) and 150.620.

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

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

(b) How much revenue will this administrative regulation

generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? No revenue will be generated in subsequent years.

(c) How much will it cost to administer this program for the first year? There will be no additional costs to administer this program for the first year.

(d) How much will it cost to administer this program for subsequent years? There will be no additional costs to administer this program in subsequent years.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

JUSTICE AND PUBLIC SAFETY CABINET
Department of Corrections
(Amendment)

501 KAR 6:130. Western Kentucky Correctional Complex.

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, 439.590 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 of its divisions. These policies and procedures are incorporated by reference in order to comply with the accreditation standards of the American Correctional Association. This administrative regulation establishes the policies and procedures for the Western Kentucky Correctional Complex.

Section 1. Incorporation by Reference. (1) "Western Kentucky Correctional Complex Policies and Procedures," January 14, 2014~~[August 14, 2012]~~, are incorporated by reference. Western Kentucky Correctional Complex policies and procedures include:

- WKCC 01-02-01 Public Information and Media Communication (Amended 1/14/14~~[6/15/12]~~)
- WKCC 02-01-01 Inmate Funds (Amended 1/14/14~~[6/15/12]~~)
- WKCC 02-01-02 Inmate Canteen (Amended 6/15/12)
- WKCC 03-00-06 Confidentiality of Information by Consultants, Contract Personnel, and Volunteers (Amended 11/14/06)
- WKCC 06-00-01 Offender Records and Information Access (Amended 8/14/12)
- WKCC 06-00-02 Administrative Process for Inmate Court Orders (Added 6/15/12)
- WKCC 08-02-01 Fire Safety Plan (Amended 8/14/12)
- WKCC 09-11-01 Tool Control (Amended 6/15/12)
- WKCC 10-02-02 Special Management Unit (SMU) Operating Procedures, Living Conditions and Classification (Amended 1/14/14~~[8/14/12]~~)
- WKCC 11-00-01 Food Service General Guidelines (Amended 6/15/12)
- WKCC 11-02-00 Food Service Budgeting and Purchasing (Added 6/15/12)
- WKCC 11-03-01 Food Service Meals, Menus, Nutrition and Special Diets (Amended 8/14/12)
- WKCC 12-00-02 Housekeeping, Sanitation and Waste Removal (Amended 8/14/12)
- WKCC 13-01-01 Use of Pharmaceutical Products (Amended 6/15/12)
- WKCC 13-02-01 Health Care Services (Amended 6/15/12)
- WKCC 13-02-02 Mental Health Services (Amended 8/14/12)
- WKCC 14-02-01 Inmate Clothing and Personal Hygiene Provisions (Amended 6/15/12)

- WKCC 14-04-01 Legal Services Program (Amended 6/15/12)
- WKCC 15-01-01 Hair and Grooming Standards (Amended 6/15/12)
- WKCC 16-01-01 Visiting Policy and Procedures (Amended 1/14/14~~[8/14/12]~~)
- WKCC 16-02-01 Inmate Correspondence (Amended 6/15/12)
- WKCC 16-03-01 Inmate Access to Telephones (Amended 10/14/05)
- WKCC 16-04-01 Inmate Packages (Amended 1/14/14~~[8/14/12]~~)
- WKCC 17-01-01 Inmate Personal Property (Amended 8/14/12)
- WKCC 17-02-01 Inmate Reception and Orientation (Amended 8/14/12)
- WKCC 19-04-01 Assignment to and Safety Inspections of Inmate Work Program Areas (Amended 8/14/12)
- WKCC 19-04-02 Farm Management and Production Guidelines (Added 6/15/12)
- WKCC 20-01-01 Education Program (Amended 8/14/12)
- WKCC 21-00-01 Library Services (Amended 8/14/12)
- WKCC 22-00-01 Inmate Recreation and Leisure Time Activities (Amended 8/14/12)
- WKCC 22-00-02 Inmate Organizations (Amended 8/14/12)
- WKCC 23-00-01 Religious Services (Amended 8/14/12)
- WKCC 24-00-01 Social Services (Amended 8/14/12)
- WKCC 25-02-01 Inmate Release Process (Amended 6/15/12)
- WKCC 25-03-01 Prerelease Programs (Amended 6/15/12)
- WKCC 26-01-01 Volunteer Services Program (Amended 6/15/12)

(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: December 18, 2013

FILED WITH LRC: January 14, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 21, 2014 at 9:00 a.m. at the Justice and Public Safety Cabinet, 125 Holmes Street, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) workdays prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: Amy V. Barker, Assistant General Counsel, Justice & Public Safety Cabinet, 125 Holmes Street, Frankfort, Kentucky 40601, phone (502) 564-3279, fax (502) 564-6686.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Amy Barker

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation incorporates by reference the policies and procedures governing the operation of the Western Kentucky Correctional Complex including the rights and responsibilities of Western Kentucky

Correctional Complex employees and the inmate population.

(b) The necessity of this administrative regulation: To conform to the requirements of KRS 196.035, 197.020 and Chapter 13A.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation establishes policies and procedures necessary for the operation of WKCC through the authority of the Cabinet and the Department of Corrections to establish regulations necessary for the functions of the department.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By providing clear and concise direction and information to Western Kentucky Correctional Complex employees and the inmate population as to their duties, rights, privileges and responsibilities.

(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 update the policies and procedures to reflect changes in operations at the institution, clarify language, make changes to conform to KRS Chapter 13A, and update ACA standards.

(b) The necessity of the amendment to this administrative regulation: To conform to the requirement of KRS 196.035 and 197.020.

(c) How the amendment conforms to the content of the authorizing statutes: It permits the Commissioner or her authorized representative to implement or amend practices or procedures to ensure the safe and efficient operation of the Western Kentucky Correctional Complex.

(d) How the amendment will assist in the effective administration of the statutes: This will help Western Kentucky Correctional Complex to operate more efficiently.

(3) Type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: 210 employees of the correctional institution, 670 inmates, and all visitors to the Western Kentucky Correctional Complex.

(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: Staff and inmates will have to follow the changes made in the policies and procedures. The institution, employees, and inmates of the Department of Corrections will have to change their actions to comply with any operational changes made by this regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): An increase in cost is not anticipated to the entities from the changes in operations made in the amendments.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The operational changes will assist in the effective and orderly management of the institution.

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

(a) Initially: No additional cost is anticipated.

(b) On a continuing basis: No additional cost is anticipated.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Funds budgeted for this biennium.

(7) Provide an assessment of whether an increase in fees or funding shall 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 anticipated.

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

(9) TIERING: Is tiering applied? No 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? The amendments to this regulation will impact the operation of Western Kentucky Correctional Complex.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 196.035, 197.020

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendments to this regulation do not create any revenue for the Western Kentucky Correctional Complex.

(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 amendments to this regulation do not create any revenue for state or local government.

(c) How much will it cost to administer this program for the first year? No new programs are created. The amendments to this regulation impact how the Western Kentucky Correctional Complex operates, but do not increase costs from what was previously budgeted to the Department of Corrections.

(d) How much will it cost to administer this program for subsequent years? The amendments to this regulation impact how the Western Kentucky Correctional Complex operates, but are not expected to increase costs from what will be budgeted to the Department of Corrections.

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:

TRANSPORTATION CABINET Department of Highways Division of Maintenance (Amendment)

603 KAR 10:010. Static advertising devices.

RELATES TO: KRS 177.572-177.576, 177.830-177.890, 177.990(2), 23 U.S.C. 131, 23 C.F.R. Part 750

STATUTORY AUTHORITY: KRS 177.860, 23 U.S.C. 131[-, 23 C.F.R. Part 750]

NECESSITY, FUNCTION, AND CONFORMITY: KRS 177.860 requires the cabinet to promulgate administrative regulations establishing standards for advertising devices. KRS 177.890 authorizes the Commissioner of Highways to enter into agreements with the United States Secretary of Transportation in order to carry out national policy relating to interstate, defense, and federal-aid primary highways within the state. Compliance with the "Highway Beautification Act", 23 U.S.C. 131, conditions retention of additional federal funding on the establishment of controls over the placement of outdoor advertising devices. This administrative regulation establishes the standards for on-premise and off-premise static advertising devices[KRS 177.860 authorizes the Department of Highways to establish reasonable standards for advertising devices on or visible from interstate, parkway, and federal-aid primary highways. KRS 177.867 requires the Department of Highways to pay just compensation for the removal of legally erected advertising devices that are no longer in compliance with state law or administrative regulation. KRS 177.890 authorizes the Commissioner of Highways to enter into agreements with the United States Secretary of Transportation in

order to carry out national policy relating to interstate, defense, and federal-aid primary highways within the state. Compliance with the "Highway Beautification Act", 23 U.S.C. Section 131 is required to receive federal highway funds. Control of outdoor advertising devices adjacent to the national highway system is required by 23 U.S.C. Section 131. 23 U.S.C. Section 131(d) conditions retention of additional federal funding on the establishment of controls over the placement of outdoor advertising devices which are more stringent than required by the general federal mandate. Commonwealth v. G.L.G., Inc., Ky., 937 S.W.2d 709 (1997) ruled that the exemption to the billboard advertising prohibition established by KRS 177.860(4) did not require a commercially or industrially developed area in which the billboard was located be zoned commercial or industrial if the billboard otherwise complied with applicable local zoning ordinances].

Section 1. General Conditions Relating to Static Advertising Devices. (1) The requirements of this section shall apply to a static advertising device that is visible from an interstate, parkway, national highway system, or federal-aid primary highway.

(2) An off-premise static advertising device upon or within 660 feet of the right-of-way shall be prohibited unless the device:

(a) Is not visible from the interstate, parkway, national highway system, or federal-aid primary highway; or

(b) Meets the following:

1. Complies with county or city zoning ordinances and regulations;

2. Is located in a commercial or industrial developed area; and

3. Complies with this administrative regulation.

(3) An on-premise static advertising device that complies with this administrative regulation is allowed:

(a) Upon or within 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway both in and outside of an urban area; or

(b) Outside of an urban area and beyond 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway; and

(c) If the device complies with this administrative regulation.

(4) A static advertising device that is visible from more than one (1) interstate, parkway, national highway system, or federal-aid primary highway shall meet the requirements for each highway independently.

(5) The erection or existence of a static advertising device shall be prohibited in a protected area if the device:

(a) Advertises an activity that is prohibited by law;

(b) Is abandoned or discontinued;

(c) Is not clean, safe, and in good repair;

(d) Is not securely affixed to a substantial structure permanently attached to the ground;

(e) Directs the movement of traffic;

(f) Interferes with, imitates, or resembles an official traffic sign, signal, or traffic control device;

(g) Prevents the driver of a vehicle from having a clear and unobstructed view of an official sign or approaching or merging traffic;

(h) Includes or is illuminated by flashing, intermittent, or moving lights;

(i) Uses lighting, unless the lighting is:

1. Effectively shielded to prevent a beam of light from being directed at the main traveled way or turning roadway of the interstate, parkway, national highway system, or federal-aid primary highway; or

2. Of low intensity that will not cause glare or impair the vision of a driver or interfere with the operation of a motor vehicle;

(j) Moves or has animated or moving parts;

(k) Is erected or maintained upon a tree;

(l) Is painted or drawn on rocks or another natural feature; or

(m) Is erected upon or overhanging the right-of-way.

(6) The criteria established in this subsection shall apply to an off-premise static advertising device located in an off-premise protected area.

(a) An off-premise static advertising device shall not exceed the maximum size established in KRS 177.863(3)(a).

(b) An off-premise static advertising device may contain up to two (2) messages per facing.

(c) An on-premise static or on-premise electronic advertising device shall not affect spacing requirements for an off-premise static advertising device.

(d) An off-premise static advertising device shall not contain extensions to the face.

(e) Static advertising devices that are no more than fifteen (15) feet apart at the nearest point between the devices and have the same ownership shall be counted as a single device.

(f) If lit, an off-premise static advertising device shall be illuminated by white lights.

(g) The name of the owner of an off-premise static advertising device shall be legible from the main traveled way and shall not be larger than twenty (20) square feet. The owner's name shall be shown without other owner information and shall not be considered a message.

(h) Maximum height of an off-premise static advertising device shall be fifty (50) feet from the ground surface to the top of the structure.

(i) To establish an off-premise protected area, the distance from the edge of a state-owned right-of-way shall be measured horizontally and at a right angle to the centerline of the interstate, parkway, national highway system, or federal-aid primary highway for a distance of 660 feet.

(j) An off-premise static advertising device permit shall not be issued for a location where vegetation has been removed by permit from right-of-way within ten (10) years and within 1,000 feet of the proposed static advertising device.

(k) An off-premise static advertising device shall not be located within 2,500 feet of a scenic strip or site.

(l) An off-premise static advertising device shall not be located in a high vehicular accident area as determined by the Transportation Cabinet and supported by a traffic engineering study.

(7) The criteria established in this subsection shall apply to a nonconforming off-premise static advertising device that is located in a protected area.

(a) A nonconforming static advertising device may continue to exist if:

1. Not abandoned or discontinued;

2. Subjected to only routine maintenance;

3. In compliance with state law and administrative regulations as well as local zoning, sign, or building restrictions at the time of the erection; and

4. The device including its structure remains substantially the same as it was on the effective date of the state law or administrative regulation that made the device nonconforming.

(b) The owner of a nonconforming static advertising device shall submit biennial updates on a completed Advertising Device Biennial Certification Form, TC Form 99-206.

(c) An incomplete or inaccurate submission shall not be considered an update submittal.

(d) The update submittal for a nonconforming static advertising device shall be submitted electronically to the department pursuant to the following table:

Dept. of Highway's District #	Submittal Year	Submittal Period*
1 & 7	Odd	January 1- April 30th
2 & 4	Even	January 1- April 30th
3 & 9	Odd	May 1st- August 31st
6 & 8	Even	May 1st- August 31st
5 & 11	Odd	September 1st – December 31st
10 & 12	Even	September 1st – December 31st

*A submittal shall be received during the submittal period to be considered.

(e) Failure to submit an update by the deadline established in paragraph (d) of this subsection shall subject the owner of the nonconforming static advertising device to action pursuant to Section 5 of this administrative regulation.

(f) The following shall be considered non-routine maintenance

to a nonconforming static advertising device:

1. Extension or enlargement of the device;
2. Replacement, rebuilding, or re-erection of a device that has not been destroyed;
3. A change in the structural support including material diameters, dimensions, or type that would result in increased economic life such as replacement of wood posts with steel posts or the replacement of a wood frame with a steel frame;
4. The addition of lights, either attached or unattached, to help illuminate the nonconforming static advertising device structure that previously had no lighting for illumination;
5. A change in the existing nonstructural external light fixtures for energy efficiency;
6. The addition of variable or changeable message capability;
7. The addition of bracing, guy wires, or other reinforcement;
8. A change in the location of the structure; or
9. A change in the direction of the face.

(g) Performance of non-routine maintenance on a nonconforming static advertising device shall constitute a violation of this administrative regulation and action shall be taken pursuant to Section 5 of this administrative regulation.

(8) The criteria established in this subsection shall apply to an on-premise static advertising device located in an on-premise protected area.

(a) An on-premise static advertising device shall not exceed the maximum size specified in KRS 177.863(3)(a) if it is placed within fifty (50) feet of the activity boundary line.

(b) If further than fifty (50) feet from the activity boundary line, an on-premise static advertising device shall not exceed:

1. Twenty (20) feet in length, width, or height; or
2. 150 square feet in area, including border and trim and excluding supports.

(c) An on-premise static advertising device shall be located on the premises and within 400 feet from the activity boundary line.

(d) No more than one (1) on-premise static advertising device or one (1) on-premise electronic advertising device shall be located at a distance greater than fifty (50) feet from the activity boundary line.

(e) If taking measurements for the placement of an on-premise static advertising device for an industrial park, the service road shall be considered within the activity boundary line for the industrial park.

(f) An on-premise static advertising device erected to advertise one (1) of the businesses in a shopping center, mall, or other combined business location shall not be located more than fifty (50) feet from the activity boundary line of the business being advertised.

(g) If taking measurements for the placement of a single on-premise static advertising device for a shopping center, mall, or other combined business location, the combined parking area shall be considered within the activity boundary line.

(h) A single on-premise static advertising device erected for a shopping center, mall, or other combined business location may:

1. Identify each of the individual businesses conducted at the location; or
2. Include a single display area used to advertise on-premise activities.

Section 2. Static Advertising Devices on Interstates and Parkways. (1) The requirements of this section shall apply to a static advertising device visible from an interstate or parkway.

(2) If it is visible from the main traveled way or turning roadway of an interstate or parkway and meets the permitting criteria established in this administrative regulation, an off-premise static advertising device located in an off-premise protected area of an interstate or parkway shall be permitted by the department.

(3) A permit shall not be issued unless an off-premise static advertising device:

- (a) Complies with Section 1 and this section of this administrative regulation;
- (b) Is erected or maintained in an off-premise protected area of an interstate or parkway;
- (c) Complies with KRS 177.830 through 177.890, this

administrative regulation, and county or city zoning ordinances and regulations;

(d) Is erected or maintained in a commercial or industrial developed area.

1. The commercial or industrial developed area shall contain at least seven (7) commercial or industrial businesses.

2. The commercial or industrial business structures shall be:

- a. Separated by no more than 1,600 feet measured from the activity boundary line of the business as outlined in subsection (8) of this section;

b. Equipped with water and electricity;

c. Open to the public with regular business hours or regularly used by the employees as their principal work station; and

d. In operation at the current location for no less than twelve (12) months prior to permit application submittal.

3. The area shall be within an incorporated municipality as the boundaries existed on September 21, 1959;

(e) Is no closer than fifty (50) feet to the edge of the main traveled way or turning roadway of the interstate or parkway; and

(f) Replaces four (4) off-premise advertising devices as established in subsection (4) of this section.

(4)(a) Four (4) off-premise advertising devices located in a protected area shall be removed prior to receiving a permit and prior to erecting a static advertising device.

(b) A permittee shall receive a conditional permit until the four (4) off-premise advertising devices are removed pursuant to paragraph (a) of this subsection.

(c) The four (4) off-premise advertising devices to be removed shall be identified in the permit application.

(d) If the permittee does not own four (4) off-premise advertising devices, the devices shall be obtained in order to comply with this subsection. In special cases, upon written petition and for good cause shown, the Commissioner of Highways may permit deviations from this paragraph.

(e) The off-premise advertising devices removed pursuant to paragraph (a) of this subsection shall be:

1. Approved by the department for removal; and
2. Nonconforming or illegal off-premise static or electronic advertising devices located on an interstate or parkway; or
3. Legal, illegal, or non-conforming static or electronic advertising devices visible from a scenic highway.

(5) If one (1) or more of the seven (7) businesses required by subsection (3) of this section is terminated or no longer exists, the off-premise static advertising device may be reclassified as a nonconforming static advertising device.

(6) An off-premise static advertising device visible from an interstate or parkway shall not be erected within 500 feet of another off-premise static advertising device on the same side of the interstate or parkway.

(7) An off-premise static advertising device visible from an interstate or parkway shall not be erected within 1,500 feet of another off-premise electronic advertising device on either side of the interstate or parkway.

(8) The requirements in this subsection shall be used to measure distances for the identification of a commercial or industrial developed area.

(a) Lines shall be drawn perpendicular to the center line of the interstate or parkway, extending from each side of the interstate or parkway.

(b) The first perpendicular line shall be drawn from the activity boundary line of the first-encountered commercial or industrial business.

(c) The last perpendicular line shall be drawn from the activity boundary line of the last-encountered commercial or industrial business.

(d) The distance between the activity boundary line of the first and last encountered commercial or industrial business shall not exceed 1,600 feet.

(e) Each perpendicular line shall extend for a distance of 660 feet from each edge of the right-of-way of the interstate or parkway.

(f) Area within the confines of the lines perpendicular to the center line of the interstate or parkway shall be considered if

establishing a commercial and industrial developed area.

(g) The static advertising device shall be on the same side of the interstate or parkway where at least four (4) of the commercial or industrial businesses are located and within 100 feet of the activity boundary line of one (1) of the four (4) businesses.

(h) A business on either side of the interstate or parkway within the confines of the lines perpendicular to the centerline of the interstate or parkway may be counted as part of the seven (7) required businesses.

Section 3. Static Advertising Devices on National Highway System and Federal-Aid Primary Highways.

(1) The requirements of this section shall apply to a static advertising device visible from a national highway system or federal-aid primary highway.

(2) If it is visible from the main traveled way or turning roadway of a national highway system or federal-aid primary highway and meets the permitting criteria established in this administrative regulation, an off-permitted static advertising device shall be permitted by the department.

(3) An off-premise static advertising device shall be prohibited in a protected area of a national highway system or federal-aid primary highway if:

(a) Prohibited by KRS 177.863(1);

(b) Within 2,500 feet of an official picnic area, golf course, public park, recreational area, forest preserve, church, school, battlefield, rest area, museum, historical monument, state park, or national park; or

(c) Within 2,500 feet of a scenic strip or site.

(4) A permit shall not be issued by the department unless an off-premise static advertising device:

(a) Complies with Section 1 and this section of this administrative regulation;

(b) Is erected and maintained in an off-premise protected area of a national highway system or federal-aid primary highway:

1. In a commercial or industrial zone; or

2. In an unzoned commercial or industrial area with a commercial or industrial activity that is located on the same side of the highway and within 700 feet of the static advertising device as outlined in subsection (6) of this section;

(c) Complies with KRS 177.830 through 177.890, this administrative regulation, and county or city zoning ordinances; and

(d) Replaces two (2) off-premise advertising devices pursuant to subsection (5) of this section.

(5)(a) Two (2) off-premise advertising devices located in a protected area shall be removed prior to receiving a permit and prior to erecting a static advertising device.

(b) A permittee shall receive a conditional permit until the two (2) devices are removed pursuant to paragraph (a) of this subsection.

(c) The two (2) off-premise advertising devices to be removed shall be identified in the permit application.

(d) If the permittee does not own two (2) off-premise advertising devices, the devices shall be obtained in order to comply with this subsection. In special cases, upon written petition and for good cause shown, the Commissioner of Highways may permit deviations from this paragraph.

(e) The off-premise advertising devices removed pursuant to paragraph (a) of this subsection shall be:

1. Approved by the department for removal; and

2. Nonconforming or illegal off-premise static or electronic advertising devices located on a national highway system or a federal-aid primary highway; or

3. Legal, illegal, or nonconforming static or electronic advertising devices visible from a scenic highway.

(6) The requirements in this subsection shall be used to measure the correct distance for an off-premise static advertising device from a commercial or industrial activity.

(a) Two (2) lines shall be drawn from the activity boundary line perpendicular to the centerline of the main traveled way to encompass the greatest longitudinal distance along the center line of the national highway system or federal-aid primary highway.

(b) Measurements shall begin at the outside edge of the activity boundary lines and shall be measured 700 feet in each direction.

(7) The criteria established in this subsection shall apply to a non-billboard off-premise static advertising device, also known as a civic or community advertising device, located in an off-premise protected area.

(a) A non-billboard off-premise static advertising device shall be prohibited on or over a state-owned right-of-way.

(b) A non-billboard off-premise static advertising device shall not affect the spacing requirements for off-premise static advertising devices on national highway system and federal-aid primary highways.

(c) A non-billboard off-premise static advertising device with multiple messages shall be limited to an overall facing size of no more than 150 square feet and each individual message shall be limited to eight (8) square feet.

(d) A non-billboard off-premise static advertising device with one (1) message shall be limited to eight (8) square feet.

(e) Spacing between two (2) non-billboard off-premise static advertising devices shall be 200 feet.

Section 4. Permits, Renewals, and Transfers. (1) The requirements of this section shall apply to static advertising devices on an interstate, parkway, national highway system, or federal-aid primary highway.

(2) Except for non-billboard off-premise static advertising devices, a permit shall be required from the department for an off-premise static advertising device located in an off-premise protected area.

(3) The initial permit shall be valid until the expiration of the applicable renewal period. If the renewal period falls within six (6) months of the initial permit issuance, the initial permit shall be good until the next renewal period.

(4) An application for an off-premise static advertising device permit shall be made on a completed Application for Off-Premise Advertising Device, TC Form 99-31.

(5) An application for a non-billboard off-premise advertising device shall be made on a completed Application For Non-Billboard Off-Premises Advertising Device, TC Form 99-207.

(6) The issuance of an off-premise static advertising device permit relevant to spacing between off-premise static or electronic advertising devices shall be determined on a first-come, first-served basis.

(7) A permittee shall submit biennial renewals. A renewal shall be made on a completed Advertising Device Biennial Certification Form, TC Form 99-206. An incomplete or inaccurate submission shall not be considered.

(8)(a) If submitting a biennial renewal, the permittee shall certify that the off-premise static advertising device meets the permit requirements of this administrative regulation.

(b) If the off-premise static advertising device no longer meets the permit requirements of this administrative regulation, the permittee may request a conditional renewal to allow the permittee to become compliant with the permit requirements.

(c) If the permittee fails to become compliant, the permit shall not be renewed and the off-premise advertising device shall be reclassified as a nonconforming static advertising device.

(9) A renewal submittal for a static advertising device shall be submitted electronically to the department pursuant to the following schedule:

Dept. of Highway's District #	Submittal Year	Submittal Period*
1 & 7	Odd	January 1- April 30th
2 & 4	Even	January 1- April 30th
3 & 9	Odd	May 1st- August 31st
6 & 8	Even	May 1st- August 31st
5 & 11	Odd	September 1st – December 31st
10 & 12	Even	September 1st – December 31st

*A submittal shall be received during the submittal period to be considered.

(10) Failure to submit a renewal by the deadline outlined in subsection (9) of this section shall result in the off-premise advertising device being designated as illegal and action shall be taken pursuant to Section 5 of this administrative regulation.

(11) A static advertising device may be sold, leased, or otherwise transferred without affecting its status, but its location shall not be changed. A transfer of ownership for a static advertising device shall be submitted on a completed Advertising Device Ownership Transfer, TC Form 99-205.

(12) An application amendment for substantial change to an approved off-premise static advertising device permit shall be submitted and approved by the department prior to work being performed.

(13) An off-premise static advertising device that has been permitted but not constructed shall not be installed if the permitted location becomes ineligible prior to installation. If the location is no longer permissible, the permit shall be cancelled.

(14) An on-premise static advertising device shall be in compliance with the provisions of this administrative regulation but shall not require a permit.

Section 5. Notice of Violations; Appeals. (1) The department shall notify the owner of the static advertising device by certified letter that the static advertising device is in violation of KRS Chapter 177 or this administrative regulation.

(2) The owner of the device shall be given thirty (30) days to respond to the violations outlined in the department's notice.

(3) If the owner fails to respond to the certified notice or fails to remedy the violations within thirty (30) days, the department may proceed to take legal action.

(4) If the owner receives a certified notice for a nonconforming off-premise static advertising device and fails to respond or remedy the violations within thirty (30) days, the device shall lose its nonconforming status.

(5)(a) An owner aggrieved by the findings of the department may request an administrative hearing in writing within twenty (20) days of the notice.

(b) A request for a hearing shall thoroughly detail the grounds upon which the hearing is requested.

(c) The hearing request shall be addressed to the Transportation Cabinet, Office of Legal Services, 200 Mero Street, Frankfort, Kentucky 40622. The administrative hearing shall be conducted pursuant to KRS Chapter 13B.

Section 6. Scenic Highways and Byways (1) After the designation of a scenic highway by the Transportation Cabinet, additional off-premise static advertising devices shall not be erected, allowed, or permitted that are visible from the scenic highway.

(2) The sponsor of a scenic byway application may petition the Transportation Cabinet to impose the same administrative regulations for static advertising devices located on scenic byways as those located on scenic highways.

(3) Only routine maintenance shall be performed on an off-premise static advertising device legally in existence on the date of the scenic highway designation.

Section 7. Penalties. (1) A static advertising device owner who willfully violates a provision of this administrative regulation shall be assessed a penalty of \$500 dollars per day, per violation pursuant to KRS 177.990(2).

(2) The department shall deny or revoke a permit if the permit application contains false or materially misleading information.

Section 8. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Application for Off-Premise Advertising Device", TC Form 99-31, May 2013;

(b) "Advertising Device Ownership Transfer", TC Form 99-205, December 2013;

(c) "Advertising Device Biennial Certification Form", TC Form 99-206, December 2013;

(d) "Application For Non-Billboard Off-Premises Advertising

Device", TC Form 99-207, December 2013;

(e) "Agreement for Carrying Out National Policy Relative to Control of Outdoor Advertising in Areas Adjacent to the National System of Interstate and Defense Highways and the Federal-Aid Primary System", December 23, 1971; and

(f) The formal designation of interstates, parkways, national highway system, and federal-aid primary highways by the Transportation Cabinet on the cabinet's Web site at: <http://maps.kytc.ky.gov/PAFOA/>.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Transportation Cabinet Building, Department of Highways, 200 Mero Street, Frankfort, Kentucky 40622, Monday through Friday, 8 a.m. to 4:30 p.m. This material is also available on the cabinet's Web site at <http://transportation.ky.gov/Construction/Pages/Kentucky-Standard-Specifications.aspx>. [Definitions. (1) "Abandoned" or "discontinued" means that for a period of one (1) year or more that the device has:

- (a) Not displayed any advertising matter;
- (b) Displayed obsolete advertising matter; or
- (c) Needed substantial repairs.

A notice that the device is for sale, rent, or lease shall not be considered advertising matter.

(2) "Activity boundary line" means the delineation on a property of those regularly used buildings, parking lots, storage and process areas which are an integral part of and essential to the primary business activity which takes place on the property. In an industrial park, the service road shall be considered within the activity boundary line for the industrial park as a separate entity.

(3) "Advertising device" or "device" means as defined in KRS 177.830(5).

(4) "Allowed" means legal to exist without a permit from the Department of Highways.

(5) "Billboard" or "off-premise advertising device" means a device that contains a message relating to an activity or product that is foreign to the site on which the device and message are located or an advertising device erected by a company or individual for the purpose of selling advertising messages for profit.

(6) "Centerline of the highway" means a line equidistant from the edges of the median separating the main traveled ways of a divided highway, or the centerline of the main traveled way of a nondivided highway.

(7) "Commercial or industrial activities" means as defined in KRS 177.830(9).

(8) "Commercial or industrial enterprise" means any activity carried on for financial gain except that it shall not include:

- (a) Leasing of property for residential purposes;
- (b) Agricultural activity or animal husbandry; or
- (c) Operation or maintenance of an advertising device.

(9) "Commercially or industrially developed area" means:

(a) Any area within 100 feet (thirty and five tenths (30.5) meters) of, and including any area where there are located within the protected area at least ten (10) separate commercial or industrial enterprises, not one of the structures from which one (1) of the enterprises is being conducted is located at a distance greater than 1620 feet (493.8 meters) from any other structure from which one (1) of the other enterprises is being conducted; and

(b) 1. Within the area there was a commercial or industrial enterprise in existence on September 21, 1959; or

2. The land use for the area was within an incorporated municipality as the boundaries existed on September 21, 1959.

(10) "Commercial or industrial zone" means as defined in KRS 177.830(7).

(11) "Comprehensively zoned" means, as it is applied to FAP highways only, that each parcel of land under the jurisdiction of the zoning authority has been placed in some zoning classification.

(12) "Department" means the Department of Highways within the Kentucky Transportation Cabinet.

(13) "Destroyed" means damage to an advertising device in excess of fifty (50) percent of the device:

- (a) Including:
 - 1. Supports;
 - 2. Poles;

- 3. Guys;
- 4. Struts;
- 5. Panels;
- 6. Facing; and
- 7. Bracing; and

(b) That to be structurally and visually acceptable, requires adding:

- 1. A guy or strut;
- 2. New supports or poles by splicing or attaching to an existing support;
- 3. Separate new auxiliary supports or poles;
- 4. New or replacement peripheral or integral structural bracing or framing; or
- 5. New or replacement panels or facing.

(14) "Electronic sign" means an on-premise advertising device whose message may be changed by electrical or electronic process, and includes the device known as the electronically changeable message center for advertising on-premise activities.

(15) "Erect" means to construct, build, raise, assemble, place, affix, attach, create, paint, draw or in any way bring into being or establish, but it shall not include any of the foregoing activities if performed as an incident to:

- (a) The change of an advertising message; or;
- (b) Customary maintenance; or
- (c) Repair of an advertising device.

(16) "Federal aid primary highway" or "FAP highway" means as defined in KRS 177.830(3) and 23 USC 103(b) and as it existed on June 1, 1991.

(17) "Identifiable" means capable of being related to a particular product, service, business or other activity even though there is no written message to aid in establishing the relationship.

(18) "Interstate highway" means as defined in KRS 177.830(2) and 23 USC 131(t).

(19) "Legible" means capable of:

- (a) Being read without visual aid by a person of normal visual acuity; or
- (b) Conveying an advertising message to a person of normal visual acuity.

(20) "Main traveled way" means the traveled way of a highway on which through traffic is carried. In the case of a divided highway, each direction has its own main traveled way. It does not include such facilities as frontage roads, turning roadways, access ramps, or parking areas.

(21) "National highway system" or "NHS" means the Kentucky highways defined in 23 USC 103 which for the purpose of outdoor advertising shall exclude the highways which are part of the interstate, parkway, or FAP system of highways.

(22) "Nonbillboard off-premise advertising device" means, as it is applicable to FAP and NHS highways only, an advertising device not located on the property which it is advertising and limited to advertising for a city, church, or civic club which includes any nationally, regionally or locally known religious or nonprofit organization.

(23) "Nonconforming advertising device" means an off-premise advertising device that was lawfully erected but:

- (a) Does not comply with the provisions of a subsequent:
- 1. State law; or
- 2. Administrative regulation; or
- (b) Later fails to comply with state law or administrative regulation due to changed conditions similar to the following:

- 1. Zoning change;
- 2. Highway relocation;
- 3. Highway reclassification; or
- 4. Change in a restriction on size, spacing or distance.

(24) "Official sign" means a sign:

- (a) Located within the highway right-of-way; and
- (b) Installed by or on behalf of:
- 1. The Department of Highways; or
- 2. Another public agency having jurisdiction; and
- (c) Which meets one (1) of the following purposes:

- 1. Denotes the location of underground utilities;
- 2. Is required by a federal, state, or local government to delineate the boundaries of a:

- a. Reservation;
- b. Park; or
- c. District;
- 3. Identifies the street or highway;
- 4. Controls traffic; or
- 5. Is required by state law.

(25) "On-premise advertising device" means an advertising device that contains a message relating to an activity conducted or the sale of goods and services within the boundaries of the property on which the device is located. It does not mean a sign which generates rental income.

(26) "Parkway" means any highway in Kentucky originally constructed as a toll road whether or not a toll for the use of the highway is currently being collected. As it relates to an advertising device, a parkway shall be considered the equivalent of an interstate highway.

(27) "Permitted" means legal to exist only if a permit is issued from the Department of Highways.

(28) "Primary business or activity" means that the sale of one product or a business activity which takes precedence over other product sales or business activities.

(29) "Protected area" means all areas within the boundaries of this Commonwealth which are adjacent to and within 660 feet (210.17 meters) of the state-owned highway right-of-way of the interstate, parkway, NHS, and FAP highways and those areas which are outside urban area boundary lines and beyond 660 feet (210.17 meters) from the right-of-way of an interstate, parkway, NHS, or FAP highway within the Commonwealth. If this highway terminate at a state boundary which is not perpendicular or normal to the center line of the highway, "protected area" also means all of these areas inside the boundaries of the Commonwealth which are adjacent to the edge of the right-of-way of an interstate highway in an adjoining state.

(30) "Public service message" means a message pertaining to an activity or service which is performed for the benefit of the public and not for profit or gain of a particular person, firm or corporation or information such as time or temperature.

(31) "Routine change of message" means, as it relates to a nonconforming advertising device, the message change on an advertising device from one (1) advertised product or activity to another. This includes the lamination or preparation of the existing panels or facings at a plant or factory for the changing of messages when this is the normal operating procedure of a company.

(32) "Routine maintenance" means, as it relates to a nonconforming advertising device:

- (a) The maintenance of an advertising device which is limited to replacement of nuts and bolts, nailing, riveting or welding, cleaning and painting, or manipulating to level or plumb the device;
- (b) The routine change of message; and
- (c) The lamination or preparation of existing panels or facings at a location other than that of the advertising device.

(d) Routine maintenance shall not mean:

- 1. Adding guys or struts for the stabilization of the device or substantially changing the device; or
- 2. Replacement or repair of panels, poles, or facings or the addition of new panels, poles, or facings;

(33) "Traveled way" means the portion of a roadway dedicated to the movement of vehicles, exclusive of shoulders.

(34) "Turning roadway" means a connecting roadway for traffic, turning between two (2) intersecting legs of an interchange.

(35) "Unzoned commercial or industrial area" means as defined in KRS 177.830(8).

(36) "Urban area" means as defined in KRS 177.830(10).

(37) "Visible" means capable of being seen, whether or not legible or identifiable without visual aid by a person of normal visual acuity and erected for the purpose of being seen from the traveled way.

Section 2. Signs on Highway Right-of-way. (1) Official signs allowed. An advertising device shall not be erected or maintained within or over the state-owned highway right-of-way except a directional or other official sign or signal erected by or on behalf of

the state or other public agency having jurisdiction.

(2) Types of official signs. The following official signs (with size limitations) may be allowed on state-owned highway right-of-way:

(a) Directional and other official device including a sign or device placed by the Department of Highways;

(b) A sign or device, limited in size to two (2) square feet (0.186 square meters), denoting the location of underground utilities; or

(c) A sign, limited in size to 150 square feet (thirteen and nine-tenths (13.9) square meters), erected by a federal, state, or local government to delineate boundaries of a reservation, park, or district.

Section 3. General Conditions Relating to Advertising Devices. The requirements of this section shall apply to an advertising device on an interstate, parkway, NHS, and FAP highway.

(1) FHWA/Kentucky agreement for the control of outdoor advertising.

(a) An advertising device which is visible from an interstate highway, parkway, NHS, or FAP highway shall be governed by the provisions of the agreement between the Kentucky Department of Highways and the Federal Highway Administration which was executed on December 23, 1971.

(b) This agreement is authorized by KRS 177.890 and 23 CFR Part 1.35 and required by 23 CFR Parts 190 and 750.

(2) Advertising device allowed if not visible. An advertising device which is not visible from the main traveled way of the interstate, parkway, NHS, or FAP highway shall be allowed in protected areas.

(3) Visible from more than one (1) highway. If an advertising device is visible from more than one (1) interstate, parkway, NHS, or FAP highway on which control is exercised, the appropriate provisions of this administrative regulation or KRS 177.830 through 177.890 shall apply to each of these highways.

(4) Nonconforming advertising device may exist. An off-premise nonconforming, but otherwise legal, advertising device may continue to exist until just compensation has been paid to the owner, if it is:

(a) Not destroyed, abandoned or discontinued;

(b) Subjected to only routine maintenance;

(c) In conformance with local zoning or sign or building restrictions at the time of the erection; and

(d) In compliance with the provisions of Section 4(3) of this administrative regulation and KRS 177.863.

(5) Nonroutine maintenance on a nonconforming device. Performance of other than routine maintenance on a nonconforming, but otherwise legal, advertising device shall cause it to lose its legal status and to be classified as illegal.

(6) Vandalized nonconforming device.

(a) The owner of a nonconforming, but otherwise legal, advertising device destroyed by vandalism or other criminal or tortious act may apply to the Department of Highways to reerect the advertising device in kind.

(b) The application for the reerection of the advertising device shall:

1. Be on Transportation Cabinet Form TC-99-31; and

2. Contain the following:

a. Plans and pictures showing the proposed new structure to be as exact a duplicate of the destroyed nonconforming advertising device as possible, including the same number of poles, type of stanchion, supports, material of poles or stanchion, and material of facing;

b. Sufficient proof that the destruction was the result of vandalism or other criminal or tortious act;

c. Ownership of the advertising device;

d. Dimensions of the destroyed advertising device;

e. Material used in erection of the destroyed advertising device;

f. Durability of the new device;

g. Stanchion type; and

h. Current lease from land owner.

(c) The Department of Highways shall not issue a notice to reconstruct until all of these conditions have been met.

(d) The owner of the vandalized nonconforming advertising device shall not reerect the advertising device until a notice to reconstruct has been issued by the Department of Highways.

(7) Required measuring methods.

(a) To establish a protected area, the distance from the edge of a state-owned highway right-of-way shall be measured horizontally along a line at the same elevation and at a right angle to the centerline of the highway for a distance of 660 feet (210.17 meters) inside urban area boundaries and to the horizon outside urban area boundary lines.

(b)1. A V-shaped or back-to-back type billboard advertising device shall not be more than fifteen (15) feet apart at the nearest point between the two (2) sign facings and shall be connected by bracing or a maintenance walkway.

2. The angle formed by the two (2) sign facings shall not be greater than forty-five (45) degrees.

(c) The spacing between advertising devices shall be measured as described in KRS 177.863(2)(c).

(8) Criteria for off-premise advertising devices. The following criteria are applicable to any off-premise advertising device located in a protected area:

(a) An off-premise advertising device shall not exceed the maximum size stated in KRS 177.863(3)(a);

(b) A V-shaped, double-faced, or back-to-back billboard advertising device shall be considered as specified in KRS 177.863(2)(b);

(c)1. A billboard advertising device may contain two (2) messages per direction of travel if the device does not exceed the maximum size stated in KRS 177.863(3)(a);

2. If a billboard advertising device contains two (2) messages on a single facing or panel, each one (1) shall occupy approximately fifty (50) percent of the device;

3. If a billboard advertising device contains two (2) messages in one (1) direction of travel, each on a separate panel or facing where one (1) panel or facing is placed above or beside the other but where the two (2) separate panels or facings are not touching:

a. There may be a size differential in the panels if dictated by the terrain of the site of the billboard advertising device and if the differential is approved by the Transportation Cabinet prior to the erection of the device; and

b. The combined size of the two (2) faces or panels of the advertising device shall not exceed the maximum size stated in KRS 177.863(3)(a).

(d) An on-premise advertising device shall not affect spacing requirements for billboard advertising.

(e) If lit, a billboard advertising device shall be illuminated by white lights.

(9) Criteria for on-premise advertising devices. The following criteria shall be applicable to an on-premise advertising device located in a protected area:

(a) An on-premise advertising device shall not exceed the maximum size specified in KRS 177.863(3)(a) if it is placed within fifty (50) feet (fifteen and two-tenths (15.2) meters) of the advertised activity boundary line.

(b)1. There shall not be more than one (1) on-premise device located at a distance greater than fifty (50) feet (fifteen and two-tenths (15.2) meters) from the activity boundary line.

2. An individual on-premise business sign erected to advertise one (1) of the businesses in a shopping center, mall, or other combined businesses location shall not be located more than fifty (50) feet (fifteen and two-tenths (15.2) meters) from the activity boundary line of the individual business.

(c) If further than fifty (50) feet from the activity boundary line, an on-premise advertising device shall not exceed:

1. Twenty (20) feet (6.09 meters) in:

a. Length;

b. Width; or

c. Height; or

2. 150 square feet (thirteen and eight-tenths (13.8) square meters) in area:

a. Including border and trim; and

b. Excluding supports.

(d)1. An on-premise advertising device shall not be located

more than 400 feet (121.9 meters), measured within the property boundary, from the advertised activity boundary line.

2. If using a corridor to reach the location of the device, the corridor shall be not less than 100 feet (thirty and five-tenths (30.5) meters) in width and shall be contiguous to an integral part of and of the same entitlement as the property on which the advertised activity is located.

3. Any other business activity which is in any manner foreign to the advertised activity shall not be located on or have use of the corridor between the advertised activity and the location of the device.

4. An activity incidental to the primary activity advertised shall not be considered in taking measurements.

5. If taking measurements for the placement of an on-premise industrial park sign as described in paragraph (j) of this subsection, the access road into the industrial park shall be considered an integral part of the property on which the activity is taking place.

6. If taking measurements for the placement of a single on-premise sign advertising a shopping center, mall, or other combined businesses location, the combined parking area shall be considered as within the activity boundary line.

(e) There shall not be requirements for spacing between on-premise advertising devices.

(f) An advertising device other than one (1) listed here shall not be located as to be visible from the main traveled way of an interstate, parkway, NHS, or FAP highway:

1. One (1) indicating the name and address of the owner, lessee or occupant of the property on which the advertising device is located;

2. One (1) showing the name or type of business or profession conducted on the property on which the advertising device is located;

3. Information required or authorized by law to be posted or displayed on the property;

4. One (1) advertising the sale or leasing of the property upon which the advertising device is located;

5. One (1) setting forth the advertisement of an activity conducted on or the sale of a product or service on the property where the advertising device is located; or

6. A sign with a maximum area of eight (8) square feet (0.743 square meters) noting credit card acceptance or trading stamps.

(g) An on-premise advertising device shall not advertise an activity, service, or business other than that conducted upon the property on which it is located.

(h) An on-premise electronic sign which contains, includes, or is illuminated by a flashing, intermittent, or moving lights shall not be used except to advertise an activity, service, business, or product available on the property on which the sign is located or to present a public service message.

1. The advertising message may contain words, phrases, sentences, symbols, trade marks, or logos.

2. A single message or segment of a message shall have a display time of at least two (2) seconds including the time needed to move the message onto the sign board, with all segments of the total message to be displayed within ten (10) seconds.

3. A message consisting of one (1) segment may remain on the sign board any amount of time in excess of two (2) seconds.

4. An electronic sign requiring more than four (4) seconds to change from one (1) single message to another shall be turned off during the change interval.

5. A display traveling horizontally across the sign board shall move between sixteen (16) and thirty-two (32) light columns per second.

6. A display may scroll onto the sign board but shall hold for two (2) seconds including the scrolling time.

7. A display shall not include an art animation or graphic that portrays motion, except for movement of a graphic onto or off of the sign board.

(i) A brand or trade name shall not be advertised on an on-premise advertising device if the sale of a product or service with the brand or trade name is incidental to the primary activity, service, or business.

(j) An industrial park type on-premise advertising device which

shall be limited in area to 150 square feet (thirteen and eight-tenths (13.8) square meters) may contain the:

1. Name of the industrial park;

2. City or county associated with the industrial park; or

3. Name of the individual business or industry located in the industrial park.

(k) A single on-premise sign erected for a shopping center, mall, or other combined businesses location may:

1. Identify each of the individual businesses conducted at the location; or

2. Include a single display area used to advertise on-premise activities.

Section 4. Specific Requirements for Advertising Devices on Interstate and Parkway Highways. (1) Permit if visible. Except for a nonconforming advertising device, an advertising device which is located in a protected area and which is visible from the main traveled way of an interstate or parkway highway shall have an approved permit from the Transportation Cabinet, Department of Highways to be a legal advertising device. An advertising device closer than fifty (50) feet (fifteen and two-tenths (15.2) meters) to the edge of the main traveled way of any interstate or parkway highway shall not be issued a permit.

(2) Criteria for billboard advertising devices.

(a) 1. A billboard advertising device may be erected or maintained in a protected area of an interstate or parkway highway if:

a. The area is a commercially or industrially developed area as defined in Section 1 of this administrative regulation; and

b. The advertising device complies with the following provisions:

(i) KRS 177.830 through 177.890;

(ii) This administrative regulation; and

(iii) Applicable county or city zoning ordinances.

2. If a business or industry on which the designation as a commercially or industrially developed area was based is terminated or abandoned, leaving less than ten (10) separate enterprises, the billboard advertising device shall be reclassified as nonconforming.

3. If the Department of Highways reclassifies the device as nonconforming, the owner shall be notified.

(b) A billboard advertising device structure designed to be primarily viewed from an interstate or parkway highway shall not be erected within 500 feet (152.4 meters) of any other off-premise advertising device on the same side of the interstate or parkway highway unless separated by a building, natural obstruction or roadway in a manner that only one (1) off-premise advertising device located within the 500 feet (152.4 meters) is visible from the interstate or parkway highway at any one time.

(3) The erection or existence of an advertising device shall not be permitted in a protected area of an interstate or parkway highway if it:

(a) Advertises an activity that is illegal, pursuant to state or federal law;

(b) Is obsolete;

(c) Is not:

1. Clean;

2. Safe; and

3. In good repair;

(d) Is not securely affixed to a substantial structure permanently attached to the ground;

(e) Attempts to:

1. Direct the movement of traffic; or

2. Interfere with, imitate, or resemble an official traffic sign, signal, or traffic control device;

(f) Prevents the driver of a vehicle from having a clear and unobstructed view of:

1. An official sign; or

2. Approaching or merging traffic;

(g) Includes or is illuminated by flashing, intermittent, or moving lights, except for an on-premise device that meets the requirements of Section 3(9)(h) of this administrative regulation;

(h) Uses lighting, unless it is:

1. Effectively shielded to prevent a beam of light from being directed at the main traveled way of a highway; or
2. Of low intensity that will not cause glare or impair the vision of a driver or interfere with the operation of a motor vehicle;
 - (i) Moves or has animated or moving parts;
 - (j) Is:
 1. Erected or maintained upon a tree;
 2. Painted or drawn on rocks or another natural feature;
 - (k) Exceeds 1,250 square feet (116.1 square meters) in area:
 1. Including border and trim; and
 2. Excluding supports;
 - (l) Is erected upon or overhanging the right-of-way of a highway; or
 - (m) Interferes with an official:
 1. Sign;
 2. Signal; or
 3. Traffic control device.
- (4)(a) To measure distances for the identification of a commercially or industrially developed area, two (2) lines shall be drawn perpendicular to the center line of the controlled interstate or parkway highway, extending from each side of the controlled highway.
 - (b) The first perpendicular line shall be drawn 100 feet from the outer edge of the first encountered separate establishment which is within the area being considered as a commercially or industrially developed area.
 - (c) The second perpendicular line shall be drawn 100 feet from the outer edge of the last encountered separate establishment which is within the area being considered as a commercially or industrially developed area.
 - (d) The distance between the first encountered establishment and the last encountered establishment shall not exceed 1620 feet.
 - (e) Each perpendicular line shall extend for a distance of 660 from each edge of the right-of-way of the controlled highway.
 - (f) All area within the confines of the lines perpendicular to the center line of the highway shall be considered when establishing a commercially and industrially developed area.
 - (g) An enterprise or structure on either side of the controlled interstate or parkway highway within the confines of the lines perpendicular to the centerline of the highway may be counted as part of the ten (10) needed.
 - (h) A pictorial representation of an eligible commercially or industrially developed area is on the Transportation Cabinet document entitled "Measurement of Commercially or Industrially Developed Area".

Section 5. Specific Requirements for Advertising Devices on Federal-aid Primary and National Highway System Highways. (1) Billboard advertising devices on NHS and FAP highways. A billboard advertising device may be permitted in a protected area of an NHS or FAP highway if it is located in an unzoned commercial or industrial area or a commercial or industrial zone and if the device complies with applicable state, county, or city zoning ordinances or administrative regulations.

(a) 1. It shall be legal to have a permitted billboard advertising device in an unzoned commercial and industrial area of an NHS or FAP highway if there is a commercial, business, or industrial activity in the area.

2. Upon the termination or abandonment of the business or industry on which the unzoned commercial or industrial area was based, the billboard advertising device shall be reclassified as nonconforming.

3. If the Department of Highways reclassifies the device as nonconforming, the owner shall be notified.

(b) Except for a nonconforming advertising device, a billboard advertising device which is visible from the main traveled way of an NHS or FAP highway and in a protected area shall have an approved permit from the Department of Highways.

(c) An unzoned commercial or industrial area shall not be created when a commercial or industrial activity is located more than 300 feet (ninety-one and four-tenths (91.4) meters) from the right-of-way of the NHS or FAP highway.

(d) 1. Minimum spacing between billboard advertising devices

in an unzoned commercial or industrial area shall be 300 feet (ninety-one and four-tenths (91.4) meters) unless separated by a building, roadway, or natural obstruction in a manner that only one (1) device located within the required spacing is visible from the highway at any time.

2. The minimum spacing requirement shall be reduced to 100 feet (thirty and four-tenths (30.4) meters) within an incorporated municipality which does not have comprehensive zoning.

(e) Minimum spacing between billboard advertising devices in any comprehensively zoned commercial or industrial area shall be 100 feet (thirty and four-tenths (30.4) meters) unless separated by a building, roadway or natural obstruction in a manner that only one (1) sign located within the required spacing is visible from the highway at any time.

(f) An advertising device which meet the criteria set forth in KRS 177.863(1) shall be prohibited.

(2) Establishing limits of an unzoned commercial or industrial area.

(a) In measuring distances for the determination of an unzoned commercial or industrial area near an NHS or FAP highway, two (2) lines shall be drawn from the activity boundary line perpendicular to the centerline of the main traveled way to encompass the greatest longitudinal distance along the center line of the highway.

(b) Measurements for establishing unzoned commercial or industrial areas shall begin at the outside edge of the activity boundary lines and shall be measured 700 feet (213.4 meters) in each direction.

(3) Nonbillboard off-premise advertising devices on NHS and FAP highways permitted.

(a) The owner of a nonbillboard off-premise advertising device shall apply for a permit in accordance with the procedures set forth in Section 6 of this administrative regulation. A metal tag corresponding to the permit shall not be issued by the Department of Highways.

(b) A nonbillboard off-premise advertising device shall not be permitted on or over the state-owned right-of-way of a NHS or FAP highway.

(c) More than one (1) nonbillboard off-premise advertising device relating to a particular city, church, or civic organization shall not be erected in each direction of travel on a NHS or FAP highway.

(d) Spacing between two (2) nonbillboard off-premise advertising devices shall be 100 feet (thirty and four-tenths (30.4) meters).

(e) A nonbillboard off-premise advertising device shall not affect the spacing requirements for billboards.

(f) A church or civic club type nonbillboard advertising device which shall be limited in area to eight (8) square feet (0.743 square meters) shall not contain a message other than the following:

1. Name and address of the church or civic club;
2. Location and time of meetings, and a directional arrow; or
3. Special events such as Vacation Bible School, revival, etc.

These temporary messages shall be in lieu of the original or a part of the original message and shall not exceed the maximum of eight (8) square feet (0.743 square meters) in area.

(4) Public service sign criteria. A public service sign may be allowed on school bus shelter if it conforms to the following requirements:

(a) The maximum size for a public service sign shall be thirty-two (32) square feet (2.97 square meters) in area including border and trim.

(b) 1. The public service sign shall contain a message of benefit to the public which occupies not less than fifty (50) percent of the area of the sign.

2. The remainder of the sign may identify the donor, sponsor or contributor of the school bus shelter.

3. The sign shall not contain any other message.

(c) Only one (1) public service sign on each school bus shelter shall face in any one (1) direction of travel.

Section 6. Required Permits for Advertising Devices. (1) Permit required.

(a) Except for a nonconforming advertising device, a permit shall be required from the Department of Highways for any off-premise advertising device located in a protected area of an interstate, parkway, NHS, or FAP highway route.

(b) A permit shall be required for each on-premise advertising device on interstate and parkway highway routes.

(c) Compliance with the provisions of this administrative regulation shall be required for an on-premise advertising device on NHS and FAP routes.

(d) By January 1, 1994 each permitted off-premise advertising device shall have a metal tag supplied by the department attached to the device.

(2) Application for an advertising device permit.

(a)1. Application for an advertising device permit shall be made on Transportation Cabinet form TC 99-31 as revised in October 1997. The application form, completed in triplicate, shall be submitted to the jurisdictional highway district office of the proposed advertising device.

2. The issuance of approved advertising device applications as they relate to the required spacing between billboards shall be determined on a "first-come, first-served" basis.

(b) The application for an advertising device permit shall be accompanied by the following:

1. Vicinity map;
2. Applicant's plot plan;
3. Location, milepoint and sign plans for the advertising device;
4. A copy of all applicable local permits;
5. A copy of the executed lease or ownership of the proposed billboard site, if applicable; and

6. If the request is for an on-premise advertising device, the application shall include a detailed description of the exact wording of the message to be conveyed on the device. This information may be furnished either by photograph, drawing, or illustration.

(c) The applicant shall submit three (3) copies of all required documentation.

(3) An approved advertising device application shall be valid for one (1) year. If the device has not been constructed and inspected for compliance in that year, the applicant shall apply for renewal of the approved application prior to the end of the year of validity.

Section 7. Illegal or Unpermitted Advertising Devices. (1) Unpermitted advertising devices. The jurisdictional chief district engineer or his representative shall notify the sign and property owner of an unpermitted or illegal advertising device by registered letter that the advertising device is in violation of Kentucky's advertising device laws or administrative regulation under the following conditions:

(a) The advertising device which is not located on state-owned highway right-of-way has not been issued a permit; or

(b) The advertising device which is not located on state-owned highway right-of-way for which a permit has been issued is found in violation of state law or this administrative regulation.

(2) Content of notice.

(a)1. If the advertising device appears to be eligible for a permit, the owner shall be given a period of ten (10) days from the date of notification by registered letter, to make application for a permit.

2. If by the end of the ten (10) days the owner does not submit a completed application to the Department of Highways, the owner shall be sent a new notice allowing him a period of thirty (30) days from the date of the second notice to remove the device.

(b) If an advertising device previously issued a permit is changed after the device received approval from the Department of Highways, the owner shall be allowed a period of thirty (30) days from the date of notification by registered letter for making the adjustments or corrections necessary to bring the advertising device into compliance with state law or administrative regulation.

(c) If a permit is not necessary for a particular advertising device but the advertising device is not in compliance with KRS Chapter 177 or this administrative regulation, the owner shall be allowed a period of thirty (30) days from the date of notification by registered letter for making any necessary adjustments or

corrections to the advertising device.

(d) An advertising device which is ineligible for a permit or otherwise in violation of KRS Chapter 177 or this administrative regulation shall be declared to be a public nuisance and the advertising device shall be removed by the permittee or owner within thirty (30) days after written notification that the advertising device is in violation.

(e) If after the thirty (30) days the noncompliant advertising device remains, the Department of Highways shall notify the owner or permittee of the action which it intends to take to have the noncompliant advertising device removed or otherwise brought into compliance.

(3) Request for reconsideration. If the permittee or owner disagrees with a notice received from the Department of Highways, within twenty (20) days of receipt of the notice, he may:

- (a) Contact the person who sent the notice to:
 1. Request reconsideration;
 2. Attempt to correct a problem with his advertising device; or
 3. Provide additional information to the Department of Highways.

(b) File an appeal in accordance with Section 9 of this administrative regulation.

Section 8. Just Compensation for the Removal of an Advertising Device. (1) Payment of just compensation shall be determined by:

- (a) An appraisal; or
- (b) A value finding;

(2) A nonconforming advertising device shall not qualify for just compensation if it:

- (a) Is:
 1. Destroyed;
 2. Abandoned; or
 3. Discontinued;
- (b) Receives more than routine maintenance; or
- (c) Does not comply with the provisions of:
 1. Section 4(3) of this administrative regulation; or
 2. KRS 177.863.

Section 9. Appeal Procedure. (1)(a) A party aggrieved by the action of the Transportation Cabinet pursuant to the provisions of this administrative regulation within twenty (20) days of the date of the notice or action may file a written appeal with the Office of General Counsel in the Transportation Cabinet, 501 High Street, Frankfort, Kentucky 40622.

(b) The appeal shall set forth the nature of the complaint and the grounds for the appeal.

(2) The administrative hearing and subsequent procedures shall be conducted pursuant to the provisions of KRS Chapter 13B.

Section 10. Scenic Byways. (1) On any NHS, FAP, interstate, or parkway highway designated by the Transportation Cabinet as a scenic byway, additional outdoor advertising devices shall not be erected, allowed or permitted after the date of the designation of the highway as scenic.

(2) The outdoor advertising devices legally in existence at the time of designation of the highway as scenic may continue to have routine maintenance.

(3) The sponsor of a scenic byway application for a highway which is not an NHS, FAP, interstate, or parkway highway may petition the Transportation Cabinet to impose the outdoor advertising device restrictions set forth in this section.

(4) The following NHS and FAP highways in Kentucky have been designated as scenic byways:

	Milepoints	
	From	To
(a) Cordell Hull Highway in Barren County:		
KY 70 - From I-65 overpass to KY 90.	5.118	5.359
KY 90 - From KY 70 at Cave City via Happy Valley Road to US 31E (Glasgow Bypass).	.000	9.923
US 31E - From KY 90 to US 68.	14.849	14.258

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US 31EX - From US 68 to Washington Street around Courthouse Square in Glasgow.	1.386	1.516
US 68 - From US 31E to US 31EX.	11.741	12.577
(b) Old Kentucky Turnpike in Larue County:		
US 31E - From the entrance to the Abraham Lincoln Birthplace National Historic Site via Hodgenville to the Nelson County Line.	7.300	20.725
(c) Old Kentucky Turnpike in Nelson County:		
US 31E - From the Larue County Line to US 62 in Bardstown.	.000	14.205
US 62 - From US 31E to US 150.	14.294	14.653
US 150 - From US 62 to entrance of My Old Kentucky Home State Park.	0.000	-0.240
(d) Shakertown Road in Mercer County:		
US 68 - From 1.2 miles east of Shaker Village to 1.2 miles west of Shaker Village.	15.652	13.252
(e) Duncan Hines Scenic Highway in Warren County:		
KY 101 - From US 31W (south) to Edmonson County Line.	11.641	12.850
US 31W - From Duncan Hines former home to KY 446 overpass.	16.559	17.569
(f) Duncan Hines Scenic Highway in Edmonson County:		
KY 101 - From Warren County Line to KY 259 at Rhoda.	0.000	4.131
KY 259 - From KY 101 at Rhoda to KY 70 (east).	9.242	12.096
KY 70 - From KY 259 (south) to KY 259 (north).	12.388	9.939
KY 259 - From KY 238 at Bee Spring to KY 738.	18.998	17.568
(g) Great River Road in Fulton County:		
KY 239 - From Hickman County Line to KY 94 in Cayce.	6.379	3.617
KY 94 - From the Tennessee State Line to KY 1099 west of Hickman.	0.000	10.902
KY 94 - From KY 1099 east of Hickman to KY 239 in Cayce.	13.642	22.121
(h) Great River Road in Hickman County:		
KY 239 - From Fulton County Line to KY 123.	0.000	3.753
KY 123 - From KY 239 to Proposed FAP 94 at Hailwell.	10.048	15.788
KY 123 - From Bottery Road in South Columbus to KY 58.	20.882	21.787
(i) Pine Mountain Road in Letcher County:		
US 119 - From KY 15 in Whitesburg to KY 806 near Oven Fork.	17.308	9.155
(j) US 68 Segment 1 in Boyle County:		
US 68 - From US 150 in Perryville to US 150 in Perryville.	7.369	7.475
(k) US 68 Segment 1 in Mercer County:		
US 68 - From US 127 at Mooreland Avenue to Jessamine County Line.	6.752	20.104
(l) US 68 Segment 1 in Jessamine County:		
US 68 - From Mercer County Line to 0.5 miles south of KY 1980.	0.000	10.610
(m) US 68 Segment 2 in Fayette County:		
US 68 - From Swigert Avenue to Bourbon County Line.	10.565	15.767
(n) US 68 Segment 2 in Bourbon County:		
US 27/68 - From Fayette County Line to US 68X in Paris.	0.000	6.765
US 68X - From 10th Street to 8th Street in Paris.	1.366	1.487
US 68X - From Paris Bypass to North Middletown Road in Paris.	2.583	2.772
US 68 - From US 68X to the Nicholas County Line.	2.360	10.814

(o) US 68 Segment 2 in Nicholas County:		
US 68 - From Bourbon County Line to KY 32/36.	0.000	3.717
(p) US 68 Segment 3 in Nicholas County:		
US 68 - From the Licking River Bridge to the Robertson County Line.	11.687	12.211
(q) US 68 Segment 3 in Robertson County:		
US 68 - From Nicholas County Line to the Fleming County Line.	0.000	1.357
(r) US 68 Segment 3 in Fleming County:		
US 68 - From Robertson County Line to the Mason County Line.	0.000	5.423
(s) US 68 Segment 3 in Mason County:		
US 68 - From Fleming County Line to US 62 in Washington.	0.000	11.854
US 62 - From KY 2515 to Ohio State Line.	13.381	18.000
(t) KY 89 (US 421 in Jackson County):		
US 421 - From the junction with KY 89 north to the junction with KY 89 south.	14.261	14.808

Section 11. Identification of NHS and FAP Highways. The following are the FAP highway segments as designated on June 1, 1991 and the current NHS highway segments which are governed by the provisions of this administrative regulation. If in existence, a noncardinal, one (1) way couplet shall also be part of the NHS and FAP system.

	Milepoint	
	From	To
(1) Adair County:		
KY 55 - From Cumberland Parkway in Columbia to the Taylor County Line.	10.059	19.006
KY 80 - From KY 55 (Courthouse Square) via Burkesville RD in Columbia to KY 61 N.	11.775	12.282
KY 61 - From KY 80 in Columbia to Green County Line.	15.248	23.997
(2) Allen County:		
US 231 - From US 31E northwest of Scottsville to Warren County Line.	.000	9.075
US 31E - From Tennessee State Line via Scottsville Bypass to Barren County Line.	.000	19.189
(3) Anderson County:		
US 127 - From Mercer County Line to US 127 Bypass.	.000	2.535
US 127B - From US 127 south of Lawrenceburg to US 127 north of Lawrenceburg.	.000	6.656
US 127 - From US 127 Bypass to Franklin County Line.	8.897	11.120
KY 151 - From US 127 Bypass to Franklin County Line.	.000	4.587
(4) Ballard County:		
US 51 - From Carlisle County Line via 4th Street in Wickliffe to Illinois State Line.	.000	8.297
US 60 - From Green Street in Wickliffe via 4th Street and Lee Street via Barlow and Kevil to McCracken County Line.	.000	16.937
KY 121 - From Carlisle County Line to 4th Street in Wickliffe.	.000	8.609
(5) Barren County:		
KY 70 - From I 65 at Cave City to KY 90.	5.118	5.359
US 68 - From US 31E (South Green Street) to KY 90 at Broadway.	12.577	12.650
KY 90 - From KY 70 at Cave City via Happy Valley Road to US 31E (Glasgow Bypass).	.000	9.923
KY 90 - From US 68 (Broadway) in Glasgow to Metcalfe County Line.	9.923	22.022

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US 68 - From US 31E (Glasgow Bypass) via Main Street to US 31EX (Business) (N Race).	11.741	12.577
US 31EX - From Washington Street in Glasgow via South Green Street to US 68 (E Main St).	1.384	1.461
US 31EX - From US 68 (East Main Street) via West Main Street to North Race Street.	1.461	1.516
US 31E - From Allen County Line via Glasgow Bypass to KY 90.	.000	14.849
(6) Bell County:		
US 25E - From Tennessee State Line to Knox County Line.	.000	18.711
US 119 - From US 25E to Harlan County Line.	.000	15.756
KY 3085 - From KY 2014 via Old US 25E to Knox County Line.	.000	2.025
(7) Bourbon County:		
US 27 - From Fayette County Line via Lexington Road and Paris Bypass to Harrison County Line.	.000	15.435
US 68 - From US 27 in Paris via Paris Bypass to Nicholas County Line.	.000	10.814
US 460 - From Scott County Line to Paris Bypass.	.000	7.696
US 68X - From 10th Street via Main Street to 8th Street in Paris.	1.366	1.487
US 68X - From Paris Bypass via Carlisle Road to North Middletown Road in Paris.	2.583	2.772
US 460 - From US 68X (Carlisle Road) via North Middletown Road to the Montgomery County Line.	9.150	21.933
KY 627 - From Clark County Line via 10th Street to US 68X (Main Street).	.000	9.511
US 460 - From US 68X (Main Street) via 8th Street to US 27 (Paris Bypass).	7.696	9.150
(8) Boyd County:		
US 23 - From Lawrence County Line via Court Street in Catlettsburg, and Greenup Avenue and Winchester Avenue in Ashland to Greenup Co. Line.	.000	21.042
KY 180 - From south limits of I-64 Interchange to US 60.	.627	2.518
US 60 - From KY 180 near Cannonsburg via 13th Street to Winchester Avenue in Ashland.	4.023	12.198
US 23S - From US 60 (Winchester Avenue) via 13th Street Bridge to Ohio State Line.	.000	.591
(9) Boyle County:		
KY 34 - From US 150 (Main Street) in Danville via Lexington Road to Garrard County Line.	12.406	17.770
KY 52 - From US 150 to Garrard County Line.	.000	5.114
US 127 - From Lincoln County Line to US 150 (3rd and Main Street intersection).	.000	5.440
US 127 - From US 127B near KY 2186 to Mercer County Line.	8.083	10.319
US 127B - From US 127 via the Danville Bypass to US 127 near KY 2168.	.000	5.270
US 150 - From Washington County Line to US 68 in Perryville.	.000	4.495
US 68 - From US 150 in Perryville to US 150 in Perryville.	7.369	7.475
US 150 - From US 68 in Perryville to Lincoln County Line.	4.495	18.766
US 127 - From US 150 at Maple Street Intersection via Main St. to US 150 at 3rd Street Intersection.	5.978	5.440

US 150B - From US 127 (Hustonville Road) to US 150 (Standford Road).	.000	2.272
(10) Bracken County:		
KY 9 - From Mason County Line to Pendleton County Line.	.000	19.857
(11) Breathitt County:		
KY 15 - From Perry County Line to Wolfe County Line.	.000	27.505
(12) Breckinridge County:		
KY 259 - From Grayson County Line to KY 79.	.000	7.901
KY 79 - From KY 259 to US 60.	5.294	14.990
KY 3199 - From Hancock County Line to US 60X (Business).	.000	1.260
US 60X - From KY 3199 to US 60 west.	.000	2.500
US 60 - From US 60X (Business) via the Cloverport and Hardinsburg Bypass to the Meade County Line.	3.500	31.788
(13) Bullitt County:		
US 31E - From Spencer County Line via the Harold Bradley Allgood Memorial Highway to the Jefferson County Line.	.000	5.185
(14) Caldwell County:		
US 641 - From Lyon County Line to Crittenden County Line.	.000	4.269
(15) Galloway County:		
KY 121 - From US 641 to Graves County Line.	14.075	24.156
US 641 - From Tennessee State Line via Murray to Marshall County Line.	.000	17.444
(16) Campbell County:		
US 27 - From Pendleton County Line via new bridge to Ohio State Line.	.000	22.622
KY 8 - From the Kenton County Line to the I-471 underpass.	.000	.998
KY 1120 - From Kenton County Line to York Street.	.000	.668
KY 1998 - From US 27 to KY 8.	2.813	5.014
KY 471 - From US 27 to I-471 (Eastbound I-275 Overpasses).	.000	.729
KY 9 - From Pendleton County Line to north limits of I-275 Interchange.	.000	17.978
(17) Carlisle County:		
US 51 - From Hickman County Line to proposed location of the Great River Road.	.000	10.725
US 51 - From a point on US 51 Mainline via the proposed Great River Road to the Ballard County Line.	.000	1.800
US 94 - From Hickman County Line via the proposed Great River Road to proposed US 51.	.000	9.000
KY 121 - From Graves County Line to Ballard County Line.	.000	9.714
(18) Carter County:		
KY 7 - From Elliot County Line to US 60 in Grayson.	.000	10.865
KY 1 - From US 60 to KY 9.	10.646	11.934
KY 9 - From KY 1 and KY 7 to Lewis County Line.	.000	18.262
(19) Casey County:		
US 127 - From Russell County Line to Lincoln County Line.	.000	23.715
(20) Christian County:		
US 41A - From Tennessee State Line to end of north exit ramp of Pennyville Parkway.	.000	13.611
US 41LP - From KY 107 to northwest urban limits of Hopkinsville at KY 91/1682.	.000	5.100

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KY 3493 - From US 41A at a point south of Hopkinsville to KY 107.	.000	1.892
US 41 - From Todd County Line to southbound exit ramp of the Pennyrite Parkway.	.000	10.325
US 41 - From US 68 to US 68 in Hopkinsville.	11.909	12.441
US 68 - From Trigg County Line to Todd County Line.	.000	21.126
KY 1682 - From US 68 to Pennyrite Parkway.	.000	3.904
(21) Clark County:		
KY 627 - From Madison County Line to KY 1958.	.000	6.360
KY 1958 - From KY 627 to north limits of the I-64 interchange.	.000	2.860
KY 627 - From southern limits of I-64 Interchange to Bourbon County Line.	9.154	14.812
(22) Clay County:		
KY 80 - From south limits of interchange ramps of Daniel Boone Parkway to US 421.	7.101	7.537
US 421 - From KY 80 to Jackson County Line.	16.915	32.841
(23) Clinton County:		
KY 90 - From Cumberland County Line to Wayne County Line.	.000	12.816
US 127 - From Tennessee State Line to Russell County Line.	.000	20.967
(24) Crittenden County:		
US 60 - From Livingston County Line to Union County Line.	.000	23.018
US 641 - From Caldwell County Line to US 60.	.000	7.494
(25) Cumberland County:		
KY 90 - From Metcalfe County Line to Clinton County Line.	.000	22.450
KY 61 - From Tennessee State Line to KY 90 West.	.000	13.701
(26) Daviess County:		
Proposed FAP 10 - From US 60 near Maceo to Indiana State Line.	.000	3.800
US 60 - From Owensboro Beltline to US 60 (Lewisport Road).	.000	2.600
US 60 - From US 60 Bypass West of Owensboro to Hancock County Line.	10.179	27.979
US 60B - From US 60 to US 60 (Lewisport Road).	.000	10.212
US 60S - From KY 54 to Owensboro Beltline.	.000	.500
KY 54 - From US 431 (Frederica Street) east limits of US 60 Bypass Interchange.	.000	2.663
US 431 - From McLean County Line to 2nd Street.	.000	14.670
KY 2245 - From US 431 (Frederica Street) via 5th Street to US 631 (Lewis Street).	.000	.246
US 231 - From US 60 Bypass via Hartford Road, Breckinridge Street, 5th Street, Lewis Street and Ohio River Bridge to Indiana State Line.	11.243	15.721
KY 2235 - From US 60 via Triplet Street to US 60.	.000	.145
KY 1467 - From US 231 (5th Street) via Breckinridge Street and Leitchfield Road to 2nd Street.	.000	.234
(27) Edmonson County:		
KY 101 - From Warren County Line to KY 259 at Rhonda.	.000	4.131
KY 259 - From KY 101 at Rhonda to KY 70 eastbound.	9.242	12.096

KY 70 - From KY 259 southbound to KY 259 northbound.	9.939	12.388
KY 259 - From KY 70 westbound to Grayson County Line.	12.096	22.692
(28) Elliott County:		
KY 7 - From Morgan County Line to Carter County Line.	.000	19.312
(29) Fayette County:		
US 27 - From Jessamine County Line via Nicholasville Road, South Limestone, Euclid Avenue, South Upper, Bolivar, Broadway, and Paris Pike to Bourbon County Line.	.000	15.767
US 25 - From Main Street (US 421) via Newtown Pike to KY 922 at Georgetown Street.	14.632	15.237
KY 4 - The entire length of New Circle Road.	.000	19.283
KY 922 - From US 25 (Georgetown Road) via Newtown Pike to north limits of I-75 Interchange.	.000	3.055
US 60 - From Woodford County Line to I-75	.000	12.805
US 68 - From southeast urban limits of Lexington at Jessamine County Line via Harrodsburg Road to KY 4.	.000	3.110
US 421 - From KY 4 via West Main Street to US 25.	.000	1.798
US 25 - From KY 418 via Richmond Road, East Main Street, and West Main Street to US 421.	8.244	14.632
KY 418 - From US 25 to southeast limits of I-75 Interchange.	.000	2.602
(30) Fleming County:		
KY 32 - From Rowan County Line to KY 11 at a point southwest of Flemingsburg.	10.615	28.293
KY 11 - From junction with KY 32 at point southwest of Flemingsburg to Mason County Line.	10.630	17.105
US 68 - From Robertson County Line to Mason County Line.	.000	5.423
(31) Floyd County:		
KY 114 - From Magoffin County Line to KY 1428 in Prestonsburg.	.000	12.430
US 23 - From Pike County Line to Johnson County Line.	.000	21.878
KY 80 - From Knott County Line to US 23.	.000	14.435
KY 1428 - From KY 114 in Prestonsburg to KY 321 in Prestonsburg.	15.605	16.091
KY 321 - From KY 1428 in Prestonsburg to KY 3 south of Auxier.	.000	4.278
KY 3 - From KY 321 south of Auxier to KY 321 near Auxier.	1.060	2.672
KY 321 - From KY 3 to Johnson County Line.	4.278	5.172
(32) Franklin County:		
US 127 - From Anderson County Line via Capital Plaza West Frankfort Connector Wilkerson Boulevard to Owen County Line.	.000	21.507
US 421 - From US 127 (Owenton Road) via Thornhill Bypass to US 460 (Georgetown Road).	3.072	4.523
KY 151 - From Anderson County Line to I-64.	.000	2.222
US 60 - From US 460 at Georgetown Road in Frankfort via Versailles Road to Woodford County Line.	10.716	14.038
US 421 - From US 127 to Henry County Line.	4.523	17.886

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US 460 - From US 60 at Versailles Road in Frankfort via Georgetown RD to Scott County Line.	.000	6.114
KY 676 - From US 127 (Lawrenceburg Road) via East-West Connector in Frankfort to US 60 (Versailles Road).	.000	5.287
(33) Fulton County:		
US 51 - From south limits of Purchase Parkway to Hickman County Line.	.000	5.472
KY 239 - From Hickman County Line to KY 94 in Cayce.	6.379	3.617
KY 94 - From the Tennessee State Line to KY 1099 west of Hickman.	0.000	10.902
KY 94 - From KY 1099 east of Hickman to KY 239 in Cayce.	13.642	22.121
KY 1099 - Fulton Bypass from KY 94 west of Hickman to KY 94 east of Hickman.	.000	2.966
(34) Gallatin County:		
KY 35 - From Owen County Line at Sparta to I-71.	.000	2.128
(35) Garrard County:		
US 27 - From Lincoln County Line to Jessamine County Line.	.000	16.510
KY 34 - From Boyle County Line to US 27.	.000	1.610
KY 1295 - From KY 52 to Madison County Line.	.000	6.928
KY 52 - From Boyle County Line to KY 954.	.000	13.476
KY 954 - From KY 52 to Madison County Line.	.000	7.564
(36) Graves County:		
US 45 - From southern interchange of Purchase Parkway to McCracken County Line.	18.950	31.580
KY 80 - From Purchase Parkway via West Broadway to US 45 at 7th Street in Mayfield.	9.638	11.461
KY 58 - From US 45 at 7th Street via East Broadway to Marshall County Line.	5.530	14.881
KY 121 - From Calloway County Line via Murray Road and 5th Street to KY 58 at Broadway.	.000	10.623
US 45 - From KY 80 at Broadway via North 8th Street to KY 121 at Housman Street.	17.219	17.952
KY 121 - From US 45 (North 8th Street) via Housman Street to Carlisle County Line.	10.623	22.559
(37) Grayson County:		
KY 259 - From Edmonson County Line to US 62 westbound.	.000	12.954
US 62 - From KY 259 southbound to KY 259 northbound.	20.787	21.296
KY 259 - From US 62 Eastbound to Breckinridge County Line.	12.954	21.459
(38) Green County:		
KY 61 - From Adair County Line to US 68.	.000	8.194
US 68 - From KY 61 southbound to West Hodgenville Avenue in Greensburg.	11.954	13.616
KY 61 - From KY 88 north of Greensburg to Larue County Line.	9.796	24.344
(39) Greenup County:		
KY 8 - From Lewis County Line to KY 8 Spur at South Portsmouth.	.000	1.956
US 23 - From Boyd County Line to south end of US Grant Bridge.	.000	28.760
KY 8 - From KY 8 Spur to US 23 at south limits of U.S. Grant Bridge in South Portsmouth.	1.956	3.023
KY 8S - From KY 8 via Carl Perkins Bridge to Ohio State Line.	.000	.610

KY 10 - From Lewis County Line to the second landward pier from river's edge in Ohio.	.000	12.844
(40) Hancock County:		
US 60 - From Daviess County Line to KY 3199 in Hawesville.	.000	10.782
KY 3199 - From US 60 in Hawesville to another junction with US 60.	.000	3.301
US 60 - From KY 3199 to Squirrel Tail Hollow Road.	13.666	14.270
KY 3199 - From another junction with US 60 to the Breckinridge County Line.	3.301	5.558
KY 69 - From US 60 at Hawesville to Indiana State Line.	13.080	13.972
(41) Hardin County:		
US 31WB - From Western Kentucky Parkway to US 31W.	.202	3.704
US 31W - From US 31W Bypass to Meade County Line.	18.818	33.040
US 31W - From Meade County Line to Jefferson County Line.	33.040	37.143
KY 61 - From Larue County Line to US 31W.	.000	5.309
(42) Harlan County:		
US 119 - From Bell County Line along existing and proposed routes to Letcher County Line.	.000	39.182
US 421 - From Virginia State Line to Leslie County Line.	.000	27.632
(43) Harrison County:		
US 27 - From Bourbon County Line to Pendleton County Line.	.000	19.472
(44) Henderson County:		
US 41 - From Pennyriple Parkway to Indiana State Line (north urban limits of Henderson).	13.414	21.193
US 41A - From Dixon Street to the northernmost loop of the interchange with US 41.	13.235	17.760
US 60 - From Union County Line to US 41A (Dixon Road).	.000	10.435
KY 425 - From US 60 (Morganfield Road) via Henderson Bypass to end of the northbound ramp junction with the Pennyriple Parkway.	.000	6.201
(45) Henry County:		
KY 55 - From Shelby County Line to KY 22 west in Eminence.	.000	1.408
KY 22 - From KY 55 south to KY 55 north.	7.420	7.522
KY 55 - From KY 22 east to US 421.	1.408	4.490
US 421 - From Franklin County Line to Shelby County Line at Pleasureville.	.000	6.434
US 421 - From Shelby County Line near Pleasureville to Trimble County Line.	6.434	25.144
(46) Hickman County:		
US 51 - From Fulton County Line to Carlisle County Line.	.000	14.451
KY 239 - From Fulton County Line to KY 123.	0.000	3.753
KY 123 - From KY 239 to Proposed FAP 94 at Hailwell.	10.048	15.788
KY 123 - From Bottery Road in South Columbus to KY 58.	20.882	21.787
Proposed FAP 94 - From KY 123 at Hailwell along Cole and Chalk Bluff Roads to KY 123 at South Columbus.	.000	6.000
KY 58 - From KY 123 to KY 80 at Columbus.	0.573	0.761
KY 80 - From KY 58 to KY 123.	0.000	1.526

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KY 123 - From KY 80 to Carlisle County Line.	21.787	22.958
(47) Hopkins County:		
KY 281 - From east limits of interchange ramps of Pennyrite Parkway to US 41.	.000	.712
US 41A - From US 41 and KY 281 to Webster County Line.	.000	13.278
(48) Jackson County:		
KY 30 - From Laurel County Line to Owsley County Line.	.000	20.919
US 421 - From Clay County Line to Rockcastle County Line.	.000	29.585
(49) Jefferson County:		
US 31W - From Hardin County Line via Dixie Highway, Bernheim Lane, 22nd Street, Dumesnil Street and 21st Street to US 31 east at Main and 2nd Streets.	.000	22.135
US 150 - From Main Street via 21st Street and 22nd Street to I-64.	.000	.741
US 150T - From 22nd Street to 21st Street.	.000	.089
US 31 - From US 31E (Main Street) via George Rogers Clark Bridge to 0.02 mile north of 4th Street in Jeffersonville, Indiana.	.000	1.122
US 31E - From Bullitt County Line to US 31W at Main and 2nd Streets.	.000	17.987
US 42 - From Baxter Avenue to US 60.	.000	.805
US 42 - From I-264 to KY 841.	5.779	8.951
KY 841 - From US 31W at Dixie Highway via Gene Snyder Freeway to I-65.	.000	10.250
KY 841 - From I-71 ramps to US 42.	34.758	37.006
KY 1934 - From KY 1230 (Cane Run Road) to I-264.	.000	7.593
US 60 - From US 42 to Story Avenue.	.000	.123
(50) Jessamine County:		
US 27 - From the Garrard County Line to Fayette County Line.	.000	15.070
US 68 - From Mercer County Line to Fayette County Line.	.000	12.060
(51) Johnson County:		
US 23 - From Floyd County Line to Lawrence County Line.	.000	18.386
US 460 - From Magoffin County Line to US 23 near Paintsville.	.000	7.809
KY 321 - From Floyd County Line to US 23 north of Paintsville.	.000	9.562
KY 40 - From US 460 to KY 321.	8.741	9.293
(52) Kenton County:		
KY 8 - From 4th Street to the Campbell County Line.	6.434	7.662
KY 1120 - From I-75 to Campbell County Line.	.000	1.212
(53) Knott County:		
KY 15 - From Letcher County Line to Perry County Line.	.000	9.380
KY 80 - From Perry County Line to Floyd County Line.	.000	20.093
(54) Knox County:		
US 25E - From Bell County Line to Laurel County Line.	.000	26.571
KY 90 - From Whitley County Line to 1.621 miles south of US 25E at KY 3041 (Proposed).	.000	2.100
KY 3041 - From 1.621 miles south of US 25E to US 25E.	.000	1.621
KY 3085 - From Bell County Line via Old US 25E to junction with US 25E.	.000	2.140
(55) Larue County:		

KY 61 - From Green County Line via Hodgenville Bypass to Hardin County Line.	.000	13.603
US 31E - From KY 61 south via Hodgenville to Nelson County Line.	6.900	20.725
(56) Laurel County:		
US 25E - From Knox County Line in Corbin to west limits of I-75 ramps.	.000	2.024
US 25 - From Daniel Boone Parkway in London to KY 490.	13.612	16.315
KY 490 - From US 25 to KY 30 at East Bernstadt.	.000	.877
KY 30 - From KY 490 to Jackson County Line.	1.404	9.806
KY 80 - From Pulaski County Line to the Daniel Boone Parkway and US 25 near London.	.000	11.083
KY 192 - From west ramps of I-75 to the Daniel Boone Parkway east of London.	18.190	22.041
(57) Lawrence County:		
US 23 - From Johnson County Line to Boyd County Line.	.000	28.947
KY 645 - From US 23 to Martin County Line.	.000	5.205
(58) Lee County:		
KY 11 - From Owsley County Line via Beattyville to Wolfe County Line.	.000	14.845
(59) Leslie County:		
US 421 - From Harlan County Line via Main Street in Hyden to KY 118 (Hyden Spur).	.000	22.613
KY 118 - From US 421 in Hyden via Hyden Spur to Daniel Boone Parkway.	.000	3.524
(60) Letcher County:		
KY 15 - From US 119 at Whitesburg to KY 7 North at Isom.	.000	9.230
KY 7 - From KY 15 to KY 15.	13.497	14.157
KY 15 - From KY 7 South in Isom to Knott County Line.	9.230	10.675
US 23 - From Virginia State Line along existing and proposed alignment to Pike County Line.	.000	7.070
US 119 - From Harlan County Line to proposed US 23 near Virginia State Line.	.000	27.798
(61) Lewis County:		
KY 9 - From Carter County Line to Mason County Line.	.000	31.218
KY 8C - From KY 10 to KY 8 south of Quincy.	.000	.127
KY 8 - From KY 8C south of Quincy to Greenup County Line.	28.575	36.910
KY 10 - From KY 9 Greenup County Line.	6.788	19.834
(62) Lincoln County:		
US 27 - From Pulaski County Line via Stanford to Garrard County Line.	.000	21.982
US 127 - From Casey County Line via Hustonville to Boyle County Line.	.000	10.847
US 150 - From Boyle County Line to US 150 Bypass.	.000	4.347
US 150B - From US 150 to US 150.	.000	3.522
US 150 - From US 150/US 150 Bypass near Preacherville Road to Rockcastle County Line.	8.705	19.665
(63) Livingston County:		
US 60 - From McCracken County Line via Smithland, Burna, and Salem to Crittenden County Line.	.000	29.059
US 62 - From Marshall County Line via Lake City to Lyon County Line.	.000	2.854
(64) Logan County:		

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US 79 - From Todd County Line via Clarksville Road and 9th Street to US 431 North.	.000	12.135
US 68 - From Todd County Line via Hopkinsville Road, 4th Street and Franklin Street to Warren County Line.	.000	26.567
US 431 - From Tennessee State Line to Muhlenberg County Line.	.000	31.898
US 68X - From US 68 west of Auburn via Old US 68 to US 60 east of Auburn.	.000	3.035
KY 3172 - From KY 73 via Old US 68 to Warren County Line.	.000	2.515
(65) Lyon County:		
US 62 - From Livingston County Line to US 641 at Fairview.	.000	10.465
US 641 - From US 62 at Fairview to Caldwell County Line.	.000	5.715
(66) McCracken County:		
US 45 - From Graves County Line via Lone Oak Road and Jackson Street to US 60 East (Jackson Street).	.000	10.820
US 60 - From Ballard County Line via Hinkleville Road and Park Avenue to US 45 (28th Street) at Laclede.	.000	13.544
US 60 - From US 45 (28th Street) via Jackson Street, 21st Street, Beltline Highway, and Division Street to the Livingston County Line.	13.544	20.028
US 62 - From US 60 to US 68.	12.881	15.513
US 68 - From US 62 to Marshall County Line.	.000	2.677
(67) McCreary County:		
US 27 - From Tennessee State Line to Pulaski County Line.	.000	22.252
KY 90 - From US 27 to Whitley County Line.	.000	11.920
(68) McLean County:		
US 431 - From Muhlenberg County Line to Daviess County Line.	.000	11.573
(69) Madison County:		
KY 1295 - From Garrard County Line to KY 52.	.000	4.529
KY 52 - From KY 1295 via Lancaster Avenue to KY 876.	5.444	10.910
KY 954 - From Garrard County Line to KY 21.	.000	.139
KY 21 - From KY 954 via Lancaster Road and Chestnut Street in Berea to US 25 at Mt. Vernon Road.	6.176	9.115
US 25 - From KY 21 West via Chestnut Street in Berea to KY 21 East.	2.863	3.810
KY 21 - From US 25 at Estill Street via Prospect Street and Big Hill Road in Berea to US 421.	9.115	14.196
KY 876 - From west limits of I-75 interchange in Richmond to KY 52 (Irvine Road).	7.097	10.755
US 25 - From US 421 via Big Hill Avenue to KY 876.	11.960	15.500
US 421 - From US 25 to Rockcastle County Line.	.000	13.031
US 421S - From KY 52 (Irvine Road) to north urban limits of Richmond at US 25.	.000	3.900
US 25 - From proposed Richmond Bypass to northwest limits of I-75 interchange at Richmond.	19.188	20.158
KY 627 - From US 25 west of I-75 to Clark County Line.	.000	6.118
(70) Magoffin County:		
KY 114 - From US 460 to Floyd County Line.	.000	5.026

US 460 - From Morgan County Line to Johnson County Line.	.000	20.426
(71) Marion County:		
US 68 - From Taylor County Line to KY 55 (Walnut St.).	.000	10.690
KY 55 - From US 68 (Main Street) via Walnut Street to KY 49 (St. Marys Road).	.000	.389
KY 49 - From KY 55 (St. Marys Road) via Walnut Street to KY 49 (Proctor Knott Avenue).	17.815	17.968
KY 55 - From KY 55 (Proctor Knott Avenue) via Walnut and Spalding Avenue to Washington County Line.	.389	4.669
(72) Marshall County:		
KY 58 - From Graves County Line to KY 80.	.000	2.156
KY 80 - From KY 58 to US 68.	.000	16.926
US 68 - From McCracken County Line to Trigg County Line.	.000	28.085
US 641 - From Calloway County Line to US 62.	.000	19.422
US 62 - From I-24 to Livingston County Line.	8.805	12.081
US 641S - From US 641 to Purchase Parkway.	.000	3.519
KY 348 - From Purchase Parkway to US 641.	7.448	8.325
(73) Martin County:		
KY 645 - From KY 40 at a point west of Inez Bypass to KY 3 northbound south of Inez.	4.682	6.605
KY 3 - From KY 645 westbound via Inez Bypass to KY 645 eastbound.	9.709	10.019
KY 645 - From KY 3 southbound via Inez Bypass to KY 40 southeast of Inez.	6.605	7.632
KY 40 - From KY 645 southeast of Inez to West Virginia State Line.	11.900	20.280
KY 645 - From Lawrence County Line to KY 40 at a point west of Inez.	.000	4.682
(74) Mason County:		
KY 11 - From Fleming County Line to KY 9.	.000	8.452
US 68 - From Fleming County Line to US 62 in Washington.	.000	11.854
US 62 - From US 68 in Washington via Lexington Road, Forest Avenue, and Aberdeen Bridge to Ohio State Line.	12.672	18.000
KY 9 - From Lewis County Line to Bracken County Line.	.000	19.554
KY 546S - From KY 9 to Ohio State Line via proposed New Bridge.	.000	4.600
(75) Meade County:		
US 31W - From Hardin County Line to Hardin County Line.	.000	3.827
US 60 - From Breckinridge County Line to US 31W.	.000	15.644
KY 144 - From US 60 to KY 448 near Buck Grove.	25.390	28.665
KY 448 - From KY 144 to KY 1051 (Brandenburg Bypass).	.000	4.392
KY 1051 - From KY 448 via Brandenburg Bypass to KY 79.	.000	2.218
KY 79 - From KY 1051 via Brandenburg Bypass to Indiana State Line.	8.237	9.912
(76) Menifee County:		
US 460 - From Montgomery County Line to Morgan County Line.	.000	19.750
(77) Mercer County:		
US 127 - From Boyle County Line via Danville Road to US 68.	.000	4.402

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US 68 - From US 127 at Mooreland Avenue to Jessamine County Line.	6.752	20.104
US 127 - From US 68 to Anderson County Line.	4.402	17.150
(78) Metcalfe County:		
KY 90 - From Barren County Line to Cumberland County Line.	.000	11.719
(79) Montgomery County:		
US 460 - From Bourbon County Line to KY 686 (Mount Sterling Bypass).	.000	8.281
KY 686 - From US 460 (Maysville Road) via Mount Sterling Bypass to US 460 (Frenchburg Road) at south urban limits of Mount Sterling.	.000	3.460
US 460 - From south urban limits of Mount Sterling to Menifee County Line.	10.702	22.151
(80) Morgan County:		
KY 7 - From US 460 in West Liberty to Elliot County Line.	.000	11.683
KY 203 - From Wolfe County Line to US 460.	.000	3.761
US 460 - From Menifee County Line via West Liberty to Magoffin County Line.	.000	28.634
(81) Muhlenberg County:		
US 431 - From Logan County Line to McLean County Line.	.000	27.779
(82) Nelson County:		
US 31E - From Larue County Line via New Haven Road, Cathedral Street, and Stephen Foster Avenue to Spencer County Line.	.000	27.588
US 62 - From US 31E to US 150.	14.294	14.653
US 150 - From US 62 to Washington County Line.	.000	7.682
(83) Nicholas County:		
US 68 - From Bourbon County Line to Robertson County Line.	.000	12.211
(84) Owen County:		
US 127 - From Franklin County Line to KY 35 at Bromley.	.000	24.687
KY 35 - From US 127 to Gallatin County Line.	.000	4.132
(85) Owsley County:		
KY 30 - From Jackson County Line to KY 11 North.	.000	11.206
KY 11 - From KY 30 to Lee County Line.	14.227	17.307
(86) Pendleton County:		
US 27 - From Harrison County Line to Campbell County Line.	.000	19.422
KY 9 - From Bracken County Line to Campbell County Line.	.000	4.339
(87) Perry County:		
KY 15 - From Knott County Line at Vieco to Breathitt County Line.	.000	25.179
KY 80 - From KY 15 to Knott County Line.	7.910	15.862
(88) Pike County:		
US 23 - From Letcher County Line along proposed and existing alignments to Floyd County Line.	.000	35.123
US 119 - From US 23 north of Pikeville to West Virginia State Line.	.000	29.748
US 460 - From US 23 north of Shelbiana to Virginia State Line.	.000	24.865
(89) Powell County:		
KY 11 - From Wolfe County Line to Mountain Parkway.	.000	3.504
(90) Pulaski County:		
US 27 - From McCreary County Line to Lincoln County Line.	.000	30.693
KY 80B - From US 27 to KY 80.	.000	2.315

KY 80 - From KY 80 Bypass to Laurel County Line.	21.636	40.393
KY 90 - From Wayne County Line to US 27.	.000	4.169
KY 461 - From KY 80 to Rockcastle County Line.	.000	8.441
(91) Robertson County:		
US 68 - From Nicholas County Line to Fleming County Line.	.000	1.357
(92) Rockcastle County:		
US 150 - From Lincoln County Line to US 25 in Mount Vernon.	.000	10.511
US 25 - From I-75 to US 150.	11.764	13.882
US 421 - From Jackson County Line to Madison County Line.	.000	.601
KY 461 - From Pulaski County Line to US 25.	.000	9.404
US 25 - From KY 461 to I-75.	15.018	15.678
(93) Rowan County:		
KY 32 - From Fleming County Line to south limits of I-64 interchange.	.000	5.784
(94) Russell County:		
US 127 - From Clinton County Line to Casey County Line.	.000	26.998
(95) Scott County:		
US 460 - From Franklin County Line to proposed Georgetown Bypass near Great Crossings.	.000	7.100
Proposed Georgetown Bypass - From US 460 Mainline near Great Crossings to US 25.	.000	3.400
US 460B - From US 25 via US 460 (Georgetown Bypass) to US 62/US 460.	.000	2.891
US 460 - From US 62/US 460B to Bourbon County Line.	8.583	15.421
(96) Shelby County:		
KY 55 - From I-64 via Taylorsville Road to US 60.	6.246	7.898
KY 55 - From KY 43/KY 2268 to Henry County Line.	9.131	17.850
US 60 - From KY 55 South (Taylorsville Road) via Midland Trail and Main Street to KY 55 North (Boone Station Road).	8.589	11.398
KY 2268 - From south end of Clear Creek Bridge via 7th Street and Pleasureville Road to KY 55.	0.000	1.308
KY 53 - From I-64 to US 60 (Frankfort Road) via Mt Eden Road.	6.188	7.978
US 421 - From Henry County Line to Henry County Line.	.000	.661
(97) Simpson County:		
US 31W - From south limits of I-65 Interchange to KY 100.	2.300	6.252
KY 100 - From US 31W Mainline to the I-65 ramps east of I-65.	9.675	12.875
(98) Spencer County:		
US 31E - From Nelson County Line to Bullitt County Line.	.000	2.433
(99) Taylor County:		
KY 55 - From Adair County Line to US 68 (Broadway).	.000	10.293
US 68 - From KY 55 via Broadway to Marion County Line.	4.939	13.600
(100) Todd County:		
US 41 - From Tennessee State Line to Christian County Line.	.000	12.458
US 79 - From Tennessee State Line to Logan County Line.	.000	10.606
US 68 - From Christian County Line to Logan County Line.	.000	14.060

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(101) Trigg County:		
US 68 - From Marshall County Line to Christian County Line.	.000	28.115
US 68X - From US 68 west of Cadiz to US 68 east of Cadiz.	0.000	4.519
KY 3468 - From US 68 east of Cadiz via Old US 68 to US 68 west of I-24.	0.000	2.840
(102) Trimble County:		
US 421 - From Henry County Line to US 42 South.	.000	6.704
US 42 - From US 421 South in Bedford to US 421 North in Bedford.	8.078	8.249
US 421 - From US 42 North to Indiana State Line.	6.704	19.287
(103) Union County:		
KY 56 - From Illinois State Line to proposed Morganfield Bypass.	.000	11.600
KY 56 - From existing US 56 via proposed Bypass to US 60.	.000	1.400
US 60 - From Crittenden County Line to proposed Morganfield Bypass.	.000	15.500
US 60 - From existing US 60 via proposed Bypass to US 60 east of Morganfield.	.000	2.900
US 60 - From proposed Bypass east of Morganfield to Henderson County Line.	18.100	26.069
KY 109 - From Webster County Line to US 60.	.000	1.536
(104) Warren County:		
KY 101 - From I-65 to US 31W.	7.861	11.641
US 31W - From KY 101 south to KY 101 north.	27.869	28.557
KY 101 - From US 31W to Edmonson County Line.	11.641	12.850
US 68 - From Logan County Line to US 31W.	.000	13.060
US 31W - From US 68 to KY 446 Overpass.	14.670	17.569
KY 446 - From US 31W to I-65.	.000	1.090
KY 880 - From KY 185 to US 68.	.000	5.128
KY 185 - From KY 880 to US 68.	.000	.292
US 231 - From Allen County Line to I-65.	.000	9.106
KY 3172 - From Logan County Line via Old US 68 to KY 240.	.000	0.300
(105) Washington County:		
KY 55 - From Marion County Line to US 150.	.000	4.551
KY 555 - From US 150 to north end of Bluegrass Parkway Interchange.	.000	14.738
US 150 - From Nelson County Line to Boyle County Line.	.000	21.359
(106) Wayne County:		
KY 90 - From Clinton County Line to Pulaski County Line.	.000	25.235
(107) Webster County:		
US 41A - From Hopkins County Line to KY 670.	.000	1.324
KY 670 - From US 41A to KY 109.	.000	2.712
KY 109 - From KY 670 to Union County Line.	2.876	14.664
(108) Whitley County:		
KY 90 - From McCreary County Line to US 25W.	.000	8.328
US 25W - From KY 90 to east limits of I-75 ramps.	22.183	29.677
KY 90 - From US 25W along proposed alignment to Knox County Line.	.000	2.000
(109) Wolfe County:		
KY 15 - From Breathitt County Line to KY 191.	.000	9.515

KY 15S - From KY 15 to westbound land of Mountain Parkway.	.000	1.054
KY 11 - From Lee County Line to Powell County Line.	.000	5.317
KY 191 - From KY 15 Spur to KY 203.	.000	10.342
KY 203 - From KY 191 to Morgan County Line.	.000	1.323
(110) Woodford County:		
US 60 - From Franklin County Line to Fayette County Line.	.000	13.039

Section 12. No Encroachment Permits for Vegetation Control. An encroachment permit shall not be issued pursuant to the provisions of 603 KAR 5:150 for the clearing or trimming of vegetation on state-owned right-of-way which is in front of an outdoor advertising device.

Section 13. Material Incorporated by Reference. (1) The following material is incorporated by reference:

(a) "The FHWA/Kentucky Agreement for the Control of Outdoor Advertising" between the Kentucky Department of Highways and the Federal Highway Administration, executed December 23, 1971; and

(b) "Application for an Advertising Device Permit," Form TC 99-31, October 1997 edition;

(c) "Measurement of Commercially or Industrially Developed Area," a Transportation Cabinet document effective March 1997.

(2) Material incorporated by reference as a part of this administrative regulation may be viewed, copied, or obtained from the Transportation Cabinet, Permits Branch, 11th Floor, State Office Building, 501 High Street, Frankfort, Kentucky 40622. The telephone number is (502) 564-4105. The business hours are 8 a.m. to 4:30 p.m. eastern time on weekdays.]

NANCY ALBRIGHT, Deputy State Highway Engineer

MIKE HANCOCK, Secretary

D. ANN DANVELO, Office of Legal Services

APPROVED BY AGENCY: January 15, 2014

FILED WITH LRC: January 15, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014 at 10:00 a.m. local time at the Transportation Cabinet, Transportation Cabinet Building, Hearing Room C121, 200 Mero Street, Frankfort, Kentucky 40622. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If you have a disability for which the Transportation Cabinet needs to provide accommodations, please notify us of your requirement five working days prior to the hearing. This request does not have to be in writing. 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 wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: D. Ann DAngelo, Asst. General Counsel, Transportation Cabinet, Office of Legal Services, 200 Mero Street, Frankfort, Kentucky 40622, phone (502) 564-7650, fax (502) 564-5238.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Ann DAngelo

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the requirements for the erection and maintenance of static advertising or billboard devices.

(b) The necessity of this administrative regulation: This regulation is necessary to inform the public of the permit requirements for static billboards.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 177.860 requires the cabinet to promulgate administrative regulations to set reasonable standards for advertising devices. 23 U.S.C. 131 ("The Highway Beautification Act") requires the state to maintain effective control over outdoor advertising devices or risk losing its apportionment of federal aid highway funds.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will clarify and update the procedures involved in the permitting, and maintenance of static advertising devices.

(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 allows a potential permittee to "swap" a number of non-conforming billboards in exchange for permitting a new, off-premise, static advertising device on interstates and parkways (where allowed under federal law) and NHS and FAP highways. The amendment also contains a provision for appealing an adverse Cabinet decision under KRS Chapter 13B. A penalty for willful violation is also included.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to update the permit requirements for static billboard devices to bring them into conformity with 23 U.S.C. 131.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment prescribes standards that pertain to the objectives set forth in KRS 177.850.

(d) How the amendment will assist in the effective administration of the statutes: The amendment updates the permit requirements.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects persons wishing to erect static billboards.

(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: Persons wishing to erect new static billboards will have to file a permit application.

(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 fees involved with this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): These requirements insure conformity in the erection of static billboard devices.

(5) Provide an estimate of how much it will cost the administrative body to implement the administrative regulation: There are no known costs associated with the amendments to this administrative regulation.

(a) Initially: N/A

(b) On a continuing basis: N/A

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: No additional 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: There is no need for the cabinet to increase fees or funding.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No fees are established by this regulation either directly or indirectly.

(9) TIERING: Is tiering applied? No. Tiering is not applied. All persons wishing to erect a static advertising device will have to apply for a permit.

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 Cabinet's Department of Highways, Division of Maintenance.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 176.860 and 23 U.S.C. 131

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. There will not be any effect on the expenditures of a state or local agency.

(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 additional 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 additional revenue.

(c) How much will it cost to administer this program for the first year? No funding increase to implement the administrative regulation will be required.

(d) How much will it cost to administer this program for subsequent years? No subsequent administrative costs are anticipated.

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 containing the federal mandate. 23 U.S.C. 131, 23 C.F.R. Part 750, and the Bonus Agreement entered into by the Federal Highway Administration (FHWA) and the Kentucky Department of Highways.

2. State compliance standards. Outdoor advertising advices are controlled on interstates, parkways, national highway system, and federal-aid primary highways. Erection of new outdoor advertising devices adjacent to or visible from a scenic highway are prohibited.

3. Minimum or uniform standards contained in the federal mandate. Outdoor advertising devices are to be controlled on interstates, parkways, national highway system, and federal-aid primary highways. No new outdoor advertising devices are allowed on scenic highways.

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

5. Justification for the imposition of the stricter standard or additional or different responsibilities or requirements. In 1961, Kentucky entered into a Bonus Agreement with FHWA. Per the agreement, Kentucky placed stricter controls on outdoor advertising devices in exchange for approximately \$2.5 million in federal bonus payments. Violation of the agreement could cause those funds to be repaid to the federal government.

LABOR CABINET
Department of Workers' Claims
(Amendment)

803 KAR 25:089. Workers' compensation medical fee schedule for physicians.

RELATES TO: KRS 342.0011(32), 342.019, 342.020, 342.035
STATUTORY AUTHORITY: KRS 342.020, 342.035(1), (4)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.035(1) requires the commissioner of the Department of Workers' Claims to promulgate administrative regulations to ensure that all fees, charges and reimbursements for medical services under KRS Chapter 342 are limited to charges that are fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers. KRS 342.035(4) requires the commissioner to promulgate an administrative regulation establishing the workers' compensation medical fee schedule for physicians. Pursuant to KRS 342.035, a schedule of fees is to be reviewed and updated, if appropriate, every two (2) years on July 1. This administrative regulation establishes the medical fee schedule for physicians.

Section 1. Definitions. (1) "Medical fee schedule" means the 2013 Kentucky Workers' Compensation Schedule of Fees[Medical Fee Schedule] for Physicians.

(2) "Physician" is defined by KRS 342.0011(32).

Section 2. Services Covered. (1) The medical fee schedule shall govern all medical services provided to injured employees by physicians under KRS Chapter 342.

(2) The medical fee schedule shall also apply to other health care or medical services providers to whom a listed CPT code is applicable unless:

(a) Another fee schedule of the Department of Workers' Claims applies;

(b) A lower fee is required by KRS 342.035 or a managed care plan approved by the commissioner pursuant to 803 KAR 25:110; or

(c) An insurance carrier, self-insured group, or self-insured employer has an agreement with a physician, medical bill vendor, or other medical provider to provide reimbursement of a medical bill at an amount lower than the medical fee schedule.

Section 3. Fee Computation. (1) The appropriate fee for a procedure covered by the medical fee schedule shall be obtained by multiplying a relative value unit for the medical procedure by the applicable conversion factor; and

(2) The resulting fee shall be the maximum fee allowed for the service provided.

Section 4. (1) A physician or healthcare or medical services provider located outside the boundaries of Kentucky shall be deemed to have agreed to be subject to this administrative regulation if it accepts a patient for treatment who is covered under KRS Chapter 342.

(2) Pursuant to KRS 342.035, medical fees due to an out-of-state physician or healthcare or medical services provider shall be calculated under the fee schedule in the same manner as for an in-state physician.

Section 5. Incorporation by Reference. (1) "2013 Kentucky Workers' Compensation Schedule of Fees for Physicians", December 2013[The Kentucky Workers' Compensation Medical Fee Schedule for Physicians, November, 2010] edition, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Workers' Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

DWIGHT T. LOVAN, Commissioner

APPROVED BY AGENCY: January 14, 2014

FILED WITH LRC: January 14, 2014 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014, at 10:30 a.m. (EST) at the offices of the Department of Workers' Claims, Prevention Park, 657 Chamberlin Avenue, 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 the end of the calendar day on Friday, February 28, 2014. 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: Charles E. Lowther, General Counsel, Department of Worker's Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601, phone (502) 782-4464, fax (502) 564-0681.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Charles E. Lowther

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation incorporates the medical fee schedule for physicians and the requirements for using the fee schedule.

(b) The necessity of this administrative regulation: Pursuant to KRS 342.035, the commissioner is required to promulgate an administrative regulation regarding fee schedules.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation incorporates the extensive fee schedule for physicians and requirements for the fee schedule.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It is imperative to have fee schedules to control the medical costs of the workers' compensation system. Injured employees should receive quality medical care and physicians should be appropriately paid.

(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: A new medical fee schedule has been completed and will be incorporated by reference.

(b) The necessity of the amendment to this administrative regulation: The statute requires the schedule of fees to be reviewed and updated every two (2) years, if appropriate.

(c) How the amendment conforms to the content of the authorizing statutes: The schedule of fees has been appropriately updated to insure that medical fees are fair, current, and reasonable for similar treatment in the same community for general health insurance payments.

(d) How the amendment will assist in the effective administration of the statutes: The schedule of fees assists the workers' compensation program by updating fees for physicians to insure injured workers get qualified and appropriate medical treatment.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: All physicians and medical providers providing services to injured workers pursuant to KRS Chapter 342, injured employees, insurance carriers, self-insurance groups, and self-insured employers and employers, third party administrators.

(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: Insurance carriers, self-insured groups, self-insured employers, third party administrators, and medical providers must purchase the new schedule of fees to accurately bill and pay for medical services. Other parties to workers' compensation claims are only indirectly impacted by the new fee schedule.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Insurance carriers, self-insured groups, self-insured employers or third party administrators and medical providers can purchase the fee schedule book with disk for \$100 or the disk for \$50.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Medical providers will receive fair, current, and reasonable fees for services provided to injured workers. Injured workers will be treated by qualified medical providers.

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

(a) Initially: The contract for reviewing and updating the physicians fee schedule and all fee schedules is \$71,250.00.

(b) On a continuing basis: No continuing costs.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Workers' Claims normal budget is the source of funding.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or 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 sets forth a current schedule of fees to be paid to physicians. Fees have been updated to be fair, current, and reasonable for similar treatment in the same community as paid by health insurers.

(9) TIERING: Is tiering applied? Tiering is not applied, because the updated fee schedule applies to all parties equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department of Workers' Claims and all parts of government with employees.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 342.035

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. As an employer, there may be some increased costs for medical services. It is impossible to estimate not knowing what medical services will be needed by injured workers.

(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 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? None

(c) How much will it cost to administer this program for the first year? No new administrative costs.

(d) How much will it cost to administer this program for subsequent years? No new administrative 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:

PUBLIC PROTECTION CABINET Kentucky Horse Racing Commission (Amendment)

810 KAR 1:040. Drug, medication, and substance classification schedule and withdrawal guidelines.

RELATES TO: KRS 230.210, 230.215, 230.240, 230.260, 230.265, 230.290, 230.320

STATUTORY AUTHORITY: KRS 230.215, 230.240, 230.260, 230.320

NECESSITY, FUNCTION, AND CONFORMITY: KRS 230.215(2) authorizes the Kentucky Horse Racing Commission to promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in Kentucky. KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation establishes the drug classification schedule in effect in Kentucky and the withdrawal guidelines for permitted drugs, medications, and substances that may be administered to race horses competing in Kentucky.

Section 1. The Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule, KHRC 40-01, shall establish the respective classifications of all substances contained therein. The Kentucky Horse Racing Commission Withdrawal Guidelines Thoroughbred, Quarter Horse, Appaloosa, and Arabian, KHRC 40-02, shall provide certain mandatory treatment requirements and guidance and advice on withdrawal intervals as contained therein.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule", KHRC 40-01, December 2013[April 2012]; and

(b) "Kentucky Horse Racing Commission Withdrawal Guidelines Thoroughbred, Quarter Horse, Appaloosa, and Arabian[.]", KHRC 40-02, December 2013[April 2012].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Horse Racing Commission, 4063 Iron Works[Ironworks] Parkway, Building B, Lexington, Kentucky 40511, Monday through Friday, 8:00 a.m. to 4:30 p.m., or on the commission's[commission] Web site at <http://khrc.ky.gov>.

ROBERT M. BECK, JR., Chairman

ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: December 30, 2013

FILED WITH LRC: January 10, 2014 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014 at 10:00 a.m., at the offices of the Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511. Individuals interested in being heard at this hearing shall notify the Kentucky Horse Racing Commission in writing by February 18, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be 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 February 28, 2014. Please send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

CONTACT PERSON: Susan B. Speckert, General Counsel, Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511, phone (859) 246-2040, fax (859) 246-2039.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Susan B. Speckert

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation incorporates the Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule (the "Schedule") and the Kentucky Horse Racing Commission Withdrawal Guidelines Thoroughbred, Quarter Horse, Appaloosa, and Arabian (the "Withdrawal Guidelines") by reference. Both documents are affected by scientific research and, thus, should be amended and updated on an ongoing basis based on developments in medical science. The Schedule establishes a classification system of regulated substances, and those classifications are then used to determine the appropriate penalty if there is a violation of 810 KAR 1:018 or 810 KAR 1:110. Thus, the Schedule provides notice to licensees regarding the potential penalty for use of a certain substance. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances. This amendment adds one substance to the list of Class A drugs contained in the Schedule. The amendment also makes certain changes to the Withdrawal Guidelines based on recommendations from the Racing Medication and Testing Consortium ("RMTC"). The RMTC is a national organization dedicated to the development, promotion, and coordination of policies, research, and educational programs that seek to ensure the fairness and integrity of horse racing and the health and welfare of racehorses and its participants at the national level. The RMTC developed regulatory thresholds and withdrawal guidance for 24 therapeutic medications having legitimate and conventional use in the care of racehorses of all breeds. The thresholds and withdrawal times are the result of a rigorous scientific process involving medication administrations to horses, serial sample collections, and statistical analysis of the resultant data. The Withdrawal Guidelines are conservative and intended to produce a substantial margin of safety so that ethical veterinary care can be provided to racehorses without fear of violating Kentucky's medication regulations. These thresholds and withdrawal guidelines have been adopted, or are under consideration, in multiple other racing jurisdictions. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing. Industry stakeholders have long maintained that uniformity is both desirable and necessary for fair competition.

(b) The necessity of this administrative regulation: The Schedule puts licensees on notice of how various regulated substances are classified. The classifications, in turn, dictate the penalties that will be levied if the substance in question is administered in violation of 810 KAR 1:018 or 810 KAR 1:110. The Withdrawal Guidelines are necessary to provide guidance to licensees regarding the regulated administration of certain medications and other substances prior to a horse competing in a race in Kentucky. The amendments are based on developments in medical science and represent a major step towards national uniformity in medication regulation and drug testing.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 230.215(2) mandates that the commission establish the conditions under which horse racing and pari-mutuel wagering thereon shall be conducted in Kentucky and charges it to, "promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth." KRS 230.240(2) further requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or

stimulants or other improper acts to horses prior to the horse participating in a race. The Schedule classifies regulated substances to give notice to licensees and to allow the commission to levy the appropriate penalty in the event of a violation. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The Schedule classifies regulated substances, thereby providing notice to licensees and allowing the commission to levy the appropriate penalty in the event of a violation of 810 KAR 1:018 or 810 KAR 1:110. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances.

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

(a) How the amendment will change this existing administrative regulation: This amendment adds one substance to the list of Class A drugs contained in the Schedule. The amendment also makes certain changes to the Withdrawal Guidelines based on recommendations from the RMTC. The RMTC developed regulatory thresholds and withdrawal guidance for 24 therapeutic medications having legitimate and conventional use in the care of racehorses of all breeds. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing.

(b) The necessity of the amendment to this administrative regulation: The amendments are based on current scientific research and represent a major step towards national uniformity in medication regulation and drug testing.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to the Schedule will insure that the commission regulates the use of medication and other substances in racehorses in a manner that is consistent with the latest developments in medical science. The Withdrawal Guidelines provide guidance to licensees on administration of certain regulated substances.

(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 licensed owners, trainers and veterinarians. It will also affect the commission as it regulates the use of medication and other substances on horses competing 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: Licensees should take notice of the classifications provided in the Schedule and should follow the recommendations given in the Withdrawal Guidelines. The commission will use the Schedule to determine the appropriate penalties for violations of 810 KAR 1:018 and 810 KAR 1:110 and take into consideration compliance with the Withdrawal Guidelines when imposing a penalty.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Compliance with this administrative regulation will not result in any additional costs to any of the entities identified in question (3).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Licensees and the commission will benefit from the updates included in the Schedule and Withdrawal Guidelines because the updates reflect developments in medical science. In addition, these thresholds and withdrawal guidelines have been adopted, or are under consideration, in multiple other racing jurisdictions. The adoption of these thresholds

and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing. Industry stakeholders have long maintained that uniformity is both desirable and necessary for fair competition.

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

(a) Initially: There are no anticipated costs to the commission.

(b) On a continuing basis: There are no anticipated costs to the commission.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: There is no additional funding necessary to implement or enforce the amendments to 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 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 or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied. All aspects of this administrative regulation will be applied equally to the affected parties.

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 Horse Racing Commission.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. Kentucky Revised Statutes 230.210, 230.215, 230.240, 230.260, 230.265, 230.290, 230.320.

(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 will have no effect on expenditures or revenues.

(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 costs associated with the implementation of the amendments to this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? There will be no costs associated with the implementation of the amendments to this administrative regulation.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

PUBLIC PROTECTION CABINET Kentucky Horse Racing Commission (Amendment)

811 KAR 1:090. Medication; testing procedures; prohibited practices.

RELATES TO: KRS 230.215, 230.240, 230.260, 230.265, 230.290, 230.310, 230.320

STATUTORY AUTHORITY: KRS 230.215, 230.240, 230.260, 230.320

NECESSITY, FUNCTION, AND CONFORMITY: KRS 230.215(2), 230.260(3), and 230.320 authorize the commission to promulgate administrative regulations prescribing the conditions under which horse racing shall be conducted in Kentucky. KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation establishes requirements and controls in the administration of drugs, medications, and substances to horses, governs certain prohibited practices, and establishes trainer responsibility relating to the health and fitness of horses.

Section 1. Definitions. (1) "AAS" or "anabolic steroid" means an anabolic androgenic steroid.

(2) "Administer" means to apply to or cause the introduction of a substance into the body of a horse.

(3) "Commission laboratory" means a laboratory chosen by the commission to test biologic specimens from a horse taken under the supervision of the commission veterinarian. (4) "Location under the jurisdiction of the commission" means a licensed race track or a training center as described in KRS 230.260(5).

(5) "Permitted NSAIDs" means the following permitted non-steroidal anti-inflammatory drugs: phenylbutazone, flunixin, and ketoprofen, if administered in compliance with Section 8 of this administrative regulation.

(6) "Positive finding" means the commission laboratory has conducted testing and determined that a drug, medication, or substance, the use of which is restricted or prohibited by this administrative regulation, was present in the sample.

(a) For the drugs, medications or substances listed in Section 2(3), 6, or 8 of this administrative regulation, a positive finding means a finding in excess of the established concentration level prescribed in those sections.

(b) Positive findings also include:

1. Substances present in the horse in excess of concentrations at which the substances might occur naturally; and

2. Substances foreign to a horse at concentrations that cause interference with testing procedures.

(7) "Primary sample" means the primary sample portion of the biologic specimen taken under the supervision of the commission veterinarian to be tested by the commission laboratory.

(8) "Split sample" means the split sample portion of the biologic specimen taken under the supervision of the commission veterinarian to be tested by the split sample laboratory.

(9) "Split sample laboratory" means the laboratory approved by the commission to test the split sample portion of the biologic specimen taken from a horse under the supervision of the commission veterinarian.

(10) "Test barn" means a fenced enclosure sufficient in size and facilities to accommodate the stabling of horses temporarily detained for obtaining specimens for pre-race and post-race testing.

(11) "Therapeutic AAS" means boldenone, nandrolone, or testosterone.

Section 2. Use of Medication. (1) Therapeutic measures and medication necessary to improve or protect the health of a horse shall be administered to a horse in training under the direction of a licensed veterinarian.

(2) Except as specifically permitted in Sections 4, 5, 6, and 8 of this administrative regulation, while participating in a race (betting or nonbetting), qualifying race, time trial, or official workout, a horse shall not carry in its body any drug, medication, substance, or metabolic derivative, that:

(a) Is a narcotic;

(b) Could serve as an anesthetic or tranquilizer;

(c) Could stimulate, depress, or affect the circulatory, respiratory, cardiovascular, musculoskeletal, or central nervous system of a horse; or

(d) Might mask or screen the presence of a prohibited drug, or

prevent or delay testing procedures.

(3) Therapeutic medications shall not be present in excess of established threshold concentrations set forth in this administrative regulation. The threshold for furosemide is set forth in Section 6 of this administrative regulation. The thresholds for permitted NSAIDS are set forth in Section 8 of this administrative regulation.

(4) A substance shall not be present in a horse in excess of a concentration at which the substance could occur naturally. It shall be the responsibility of the commission to prove that the substance was in excess of normal concentration levels.

(5) It shall be prima facie evidence that a horse was administered and carried, while running in a race (betting or nonbetting), qualifying race, time trial, or official workout, a drug, medication, substance, or metabolic derivative thereof, prohibited by this section, if:

(a) A biologic specimen from the horse was taken under the supervision of the commission veterinarian promptly after a horse ran in a race (betting or nonbetting), qualifying race, time trial, or official workout; and

(b) The commission laboratory presents to the commission a report of a positive finding.

(6) The commission shall utilize the Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule, as provided in 811 KAR 1:093, for classification of drugs, medications, and substances violating this administrative regulation. Penalties for violations of this administrative regulation shall be implemented in accordance with 811 KAR 1:095.

Section 3. Treatment Restrictions. (1) Except as set forth in Section 4 of this administrative regulation, ~~[or the oral administration of phenylbutazone as set forth in Section 8 of this administrative regulation,]~~ a person other than a veterinarian licensed to practice veterinary medicine in Kentucky and licensed by the commission shall not administer a prescription or controlled drug, medication, or other substance to a horse at a location under the jurisdiction of the commission.

(2) The only injectables allowed within twenty-four (24) hours prior to post time of the race in which the horse is entered shall be furosemide, as set forth in Section 6 of this administrative regulation.

(3) Except as set forth in subsection (5) of this section, a person other than a veterinarian licensed to practice veterinary medicine in Kentucky and licensed by the commission shall not possess a hypodermic needle, syringe, or injectable of any kind at a location under the jurisdiction of the commission.

(4) A veterinarian licensed to practice veterinary medicine in Kentucky and licensed by the commission shall use only single-use disposable needles and syringes, and shall dispose of them in a container approved by the commission veterinarian.

(5) If a person regulated by the commission, has a medical condition that makes it necessary to possess a needle and syringe at a location under the jurisdiction of the commission, the person shall request prior permission from the judges and furnish a letter from a licensed physician explaining why it is necessary for the person to possess a needle and syringe. The judges may grant approval for a person to possess and use a needle and syringe at a location under the jurisdiction of the commission, but may establish necessary restrictions and limitations.

(6) A commission employee may accompany a veterinarian at a location under the jurisdiction of the commission and take possession of a syringe, needle, or other device used to administer a substance to a horse.

Section 4. Certain Permitted Substances. Liniments, antiseptics, antibiotics, ointments, leg paints, washes, and other products commonly used in the daily care of horses may be administered by a person other than a licensed veterinarian if:

(1) The treatment does not include any drug, medication, or substance otherwise prohibited by this administrative regulation;

(2) The treatment is not injected; and

(3) The person is acting under the direction of a licensed trainer or veterinarian licensed to practice veterinary medicine in

Kentucky and licensed by the commission.

Section 5. Anti-Ulcer Medications. The following anti-ulcer medications may be administered orally, at the dosage stated in this section, up to twenty-four (24) hours prior to post time of the race in which the horse is entered:

(1) Cimetidine (Tagamet®): 8-20 mg/kg;

(2) Omeprazole (Gastrogard®): two and two-tenths (2.2) grams;

(3) Ranitidine (Zantac®): eight (8) mg/kg; and

(4) Sulcrafate: 2-4 grams.

Section 6. Furosemide Use on Race Day. (1) Furosemide may be administered, in accordance with this section, to a horse that is entered to compete in a race (betting or nonbetting), qualifying race, time trial, or official workout.

(2)(a) The commission veterinarian shall administer furosemide prior to a race (betting or nonbetting), time trial, or official workout.

(b) If the commission veterinarian is unavailable to administer furosemide to a horse prior to a race, the commission shall approve a licensed veterinarian to perform the administration. The approved licensed veterinarian shall agree to comply with all of the applicable administrative regulations regarding the administration of furosemide on race day.

(c) If the furosemide is administered by an approved licensed veterinarian, the administering veterinarian shall provide a written report to the commission veterinarian no later than two (2) hours prior to post time of the race in which the horse receiving furosemide is competing.

(3) Furosemide may be used under the following circumstances:

(a) Furosemide shall be administered on the grounds of the racing association at which the horse will compete or work;

(b) Except for qualifying races, furosemide shall be administered by a single intravenous injection, not less than four (4) hours prior to post time for the race, time trial, or official workout in which the horse is entered;

(c) The furosemide dosage administered shall not exceed 500 mg, nor be less than 150~~[be less than 100 mg and shall not exceed 250] mg;~~

(d) The specific gravity of a post-race urine sample shall not be below 1.010. If the specific gravity of the post-race urine sample is determined to be below 1.010, a quantification of furosemide in blood serum or plasma shall be performed. If a horse fails to produce a urine specimen, the commission laboratory shall perform a quantification of furosemide in the blood serum or plasma specimen. Concentrations above 100 nanograms of furosemide per milliliter of blood serum or plasma shall constitute a violation of this section; and

(4) The initial cost of administering the furosemide shall be twenty (20) dollars per administration. The commission shall monitor the costs associated with administering furosemide and consult with industry representatives to determine if the cost should be lowered based on prevailing veterinarian services and supplies. The commission shall maintain records documenting the basis for its determination, and if the cost is determined to be less than twenty (20) dollars per administration, then the commission shall lower the cost accordingly. The cost shall be prominently posted in the racing office.

Section 7. Furosemide Eligibility. (1)(a) A horse shall be eligible to qualify with furosemide if the licensed trainer or a licensed veterinarian determines that it would be in the horse's best interest to race with furosemide. Notice that a horse eligible to receive furosemide will race with or without furosemide shall be made at the time of entry to ensure public notice, including publication in the official racing program.

(b) It shall constitute a violation of this administrative regulation if notice is made pursuant to this section that a horse will race with furosemide, and the post-race urine, blood serum, or plasma does not show a detectable concentration of furosemide in the post-race urine, blood serum, or plasma.

(c) Horses eligible for furosemide and entered to start may be monitored by a commission-approved representative during the four (4) hour period prior to post time of the race in which the horse is entered.

(2) After a horse has been determined to no longer be required to receive furosemide, the horse shall not be eligible to receive furosemide unless the licensed trainer or a licensed veterinarian determines that it would be in the horse's best interests to race with furosemide and the licensed trainer or a licensed veterinarian complies with the requirements of this section.

Section 8. Permitted Non-steroidal Anti-Inflammatory Drugs (NSAIDs). (1) One (1) of the NSAIDs listed in this section may be used not less than twenty-four (24) hours prior to post time for the race for which the horse is entered if the concentration in the horse's specimen does not exceed the levels set forth in this section when tested post-race.

(2) Phenylbutazone.

(a) A single~~[oral—or]~~ intravenous administration of phenylbutazone may be administered not less than twenty-four (24) hours prior to post time of the race for which the horse is entered.

(b) The phenylbutazone dosage administered shall not exceed[
 1. Two (2) mg/lb oral; or
 2.] two (2) mg/lb intravenous.

(c) A post-race biologic specimen of phenylbutazone reported to exceed a level of two (2)~~[five (5)]~~ micrograms per milliliter of blood serum or plasma shall be considered a violation of this section.~~[(d) The oral administration of phenylbutazone may be performed by the trainer.]~~

(3) Flunixin.

(a) A single intravenous administration of flunixin may be administered not less than twenty-four (24) hours prior to post time of the race for which the horse is entered.

(b) The flunixin dosage administered shall not exceed .5 mg/lb.

(c) A post-race biologic specimen of flunixin reported to exceed a level of twenty (20) nanograms per milliliter of blood serum or plasma shall be considered a violation of this section.

(4) Ketoprofen.

(a) A single intravenous administration of ketoprofen may be administered not less than twenty-four (24) hours prior to post time of the race for which the horse is entered.

(b) The ketoprofen dosage administered shall not exceed 1 mg/lb.

(c) A post-race sample of ketoprofen reported to exceed a level of ten (10) nanograms per milliliter of blood serum or plasma shall be considered a violation of this section.

(5) Phenylbutazone, flunixin or ketoprofen, injected intravenously, shall be administered by a licensed veterinarian approved by the commission.

(6)(a) The use of any NSAID other than the permitted NSAIDs, and the use of multiple permitted NSAIDs shall be discontinued at least forty-eight (48) hours prior to post time for the race in which the horse is entered.

(b) A finding of phenylbutazone below a concentration of one-half (.5)~~[one (1)]~~ microgram per milliliter of blood serum or plasma shall not constitute a violation of this section.

(c) A finding of flunixin below a concentration of three (3) nanograms per milliliter of blood serum or plasma shall not constitute a violation of this section.

(7) A horse that has been administered phenylbutazone, flunixin, or ketoprofen shall be subject to having a biologic specimen collected under the supervision of the commission veterinarian to determine the quantitative phenylbutazone, flunixin, or ketoprofen level present in the horse or the presence of other drugs in the horse.

Section 9. Anabolic Steroids. (1) An exogenous AAS shall not be present in a horse that is racing. The detection of an exogenous AAS or metabolic derivative in a post-race or a pre-race sample after the horse has been entered shall constitute a violation of this administrative regulation.

(2) The detection in a post-race sample of an endogenous AAS or metabolic derivative where the concentration of the AAS, a metabolite, a marker, or any relevant ratio as has been published in peer-reviewed scientific literature deviates from a naturally occurring physiological level shall constitute a violation of this administrative regulation. The following shall be deemed to be naturally occurring physiological levels:

(a) Boldenone (free and conjugated):

1. In male horses other than geldings - 15 ng/ml in urine or 200 pg/ml in blood serum or plasma; and

2. In geldings and female horses, boldenone shall not be permitted.

(b) Nandrolone (free and conjugated):

1. In geldings - 1 ng/ml in urine or 50 pg/ml in blood serum or plasma;

2. In fillies and mares - 1 ng/ml in urine or 50 pg/ml in blood serum or plasma; and

3. In male horses other than geldings - 45 ng/ml of metabolite, 5 α -estrane-3 β , 17 α -diol in urine or a ratio in urine of 5 α -estrane-3 β , 17 α -diol to 5 α -estrane-3 β , 17 α -diol of >1:1.

(c) Testosterone (free and conjugated):

1. In geldings - 20 ng/ml in urine or 25 pg/ml in blood serum or plasma; and

2. In fillies and mares - 55 ng/ml in urine or 25 pg/ml in blood serum or plasma.

(3) In accordance with this subsection, a horse may receive one (1) therapeutic AAS.

(a) The therapeutic AAS shall be given for the sole purpose of treating an existing illness or injury having been diagnosed by the regular attending veterinarian. An owner or trainer who is uncertain about whether a particular purpose is considered to be therapeutic shall consult with the commission prior to administration.

(b) The horse shall be ineligible to race in Kentucky until all of the following have occurred:

1. A minimum of sixty (60) days has passed since the administration of the therapeutic AAS to the horse;

2. A relevant specimen is taken from the horse;

3. The sample is tested for AAS by a laboratory from the approved list established by the commission at the expense of the owner of the horse; and

4. The commission has received a report from the laboratory of a negative finding regarding the sample.

(c) A report from the commission laboratory of a negative finding in a pre-race sample does not provide a safe harbor for the owner, trainer, veterinarian or horse. A report from the commission laboratory of a positive finding in a post-race sample shall be treated as a violation of this administrative regulation even if there was a negative finding by the commission laboratory in a pre-race sample.

(d) The horse shall not be entered to race until at least sixty (60) days after the administration of the therapeutic AAS to the horse.

(e) Procedures for administration of therapeutic AAS.

1. A therapeutic AAS shall be administered by a licensed veterinarian.

2. Other treatment methods shall be investigated prior to considering the use of therapeutic AAS.

3. Medical records for the horse shall document:

a. Consideration of alternative treatment methods; and

b. The necessity for administering the therapeutic AAS.

4. The administering veterinarian shall record on the Therapeutic AAS Administration Form the following information:

a. The therapeutic AAS administered, the amount in milligrams, route, and site of administration;

b. The date and time of administration;

c. The name, age, sex, color, and registration certificate number of the horse to which the therapeutic AAS is administered; and

d. The diagnosis and justification for administration of the therapeutic AAS to the horse.

5. The Therapeutic AAS Administration Form shall be signed by the veterinarian administering the medication.

6. The Therapeutic AAS Administration Form shall be delivered

electronically to the commission equine medical director within seventy-two (72) hours after administration. If the Therapeutic AAS Administrative Form cannot be delivered electronically, the veterinarian shall file the form with the equine medical director in person or through the mail. The submitting veterinarian shall confirm receipt by the equine medical director.

(4) Substances referred to in subsections (1) and (2) of this section are "Class B" drugs. A positive test for an exogenous AAS or for an amount of an endogenous AAS in excess of a concentration referred to in subsection (2) of this section shall be subject to the penalties referred to in 811 KAR 1:095.

(5)(a) The detection of a therapeutic AAS or metabolic derivative in any sample in excess of a threshold level set forth in subsection (2) of this section shall constitute a violation.

(b) Each separate therapeutic AAS detected in excess of a threshold level shall constitute a separate violation.

(6) The trainer and veterinarian for the horse shall be charged accordingly and shall be subject to penalties for a violation of this administrative regulation.

(7)(a) A claimed horse may be tested for the presence of an AAS if the claimant requests the test when the claim form is completed and deposited in the association's claim box. The claimant shall bear the costs of the test. The results of the test shall be reported to the presiding judge.

(b) If a test is positive, the claim may be voided at the option of the claimant and the claimant shall be entitled to return of all sums paid for the claimed horse, expenses incurred after the date of the claim, and the costs of testing.

(c) If the test is negative, the claimant shall reimburse the entity paying for the testing or the prior owner for the cost of the testing.

(d) While awaiting test results, a claimant:

1. Shall exercise due care in maintaining and boarding a claimed horse; and

2. Shall not materially alter a claimed horse.

(8) The gender of the horse from which a post-race biologic specimen is collected shall be identified to the commission veterinarian and the testing laboratory.

(9) Only a licensed veterinarian may possess or administer a therapeutic AAS.

Section 10. Test Barn. (1) During a licensed meet, a licensed association shall provide and maintain a test barn on association grounds.

(2) The test barn shall be a fenced enclosure sufficient in size and facilities to accommodate the stabling of horses temporarily detained for the taking of biologic specimens for pre-race and post-race testing.

(3) The test barn shall be under the supervision and control of the commission veterinarian.

Section 11. Sample Collection, Testing and Reporting. (1) Sample collection shall be done in accordance with the procedures provided in 811 KAR 1:260 and under the instructions provided by the commission veterinarian.

(2) The commission veterinarian shall determine a minimum sample requirement for the commission laboratory which shall be uniform for each horse and which shall be separated into primary and split samples.

(3) An owner or trainer may request that a split sample be:

(a) Taken from a horse he owns or trains by the commission veterinarian; and

(b) Tested by the split sample laboratory.

(4) The cost of testing under subsection (3) of this section, including shipping, shall be borne by the owner or trainer requesting the test.

(5)(a) Stable equipment other than that necessary for washing and cooling out a horse shall not be permitted in the test barn.

(b) Buckets and water shall be furnished by the commission veterinarian.

(c) If a body brace is to be used on a horse, it shall:

1. Be supplied by the trainer; and

2. Applied only with the permission and in the presence of the commission veterinarian or his designee.

(d) A licensed veterinarian may attend to a horse in the test barn only with the permission of, and in the presence of, the commission veterinarian or his designee.

(6) Within five (5) business days of receipt of notification by the commission laboratory of a positive finding, the commission shall notify the owner and trainer orally or in writing of the positive finding.

(7) The judges shall schedule a hearing within fourteen (14) calendar days of notification by the commission to the owner and trainer. The hearing may be continued if the judges determine that a continuance is necessary to effectively resolve the issue.

Section 12. Storage and Shipment of Split Samples. (1) Split samples shall be secured and made available for further testing in accordance with the following procedures:

(a) Split samples shall be secured in the test barn in the same manner as the primary samples for shipment to the commission laboratory as addressed in Section 11 of this administrative regulation, until the primary samples are packed and secured for shipment to the commission laboratory. Split samples shall then be transferred to a freezer or refrigerator at a secure location approved and chosen by the commission;

(b) A freezer or refrigerator for storage of split samples shall be equipped with a lock. The lock shall be secured to prevent access to the freezer or refrigerator at all times except as specifically provided by paragraph (c) of this subsection;

(c) A freezer or refrigerator for storage of split samples shall be opened only for depositing or removing split samples, for inventory, or for checking the condition of samples;

(d) A log shall be maintained by the commission veterinarian that shall be used each time a split sample freezer or refrigerator is opened to specify each person in attendance, the purpose for opening the freezer or refrigerator, identification of split samples deposited or removed, the date and time the freezer or refrigerator was opened, the time the freezer or refrigerator was closed and verification that the lock was secured prior to and after opening of the freezer or refrigerator. A commission veterinarian or his designee shall be present when the freezer or refrigerator is opened;

(e) Evidence of a malfunction of a split sample freezer or refrigerator shall be documented in the log; and

(f) The commission shall be considered the owner of a split sample.

(2)(a) A trainer or owner of a horse receiving notice of a positive finding may request that a split sample corresponding to the portion of the sample tested by the commission laboratory be sent to the split sample laboratory. The party requesting the split sample shall select from a list of laboratories approved by the commission to perform the analysis.

(b) The request shall be made in writing and delivered to the judges within three (3) business days after the trainer or owner of the horse receives oral or written notice of the positive finding by the commission laboratory.

(c) A split sample so requested shall be shipped as expeditiously as possible.

(3)(a) The owner or trainer requesting testing of a split sample shall be responsible for the cost of the testing, including the cost of shipping.

(b) Failure of the owner, trainer or a designee to appear at the time and place designated by the commission veterinarian in connection with securing, maintaining and shipping the split sample shall constitute a waiver of any right to be present during split sample testing procedures.

(c) Prior to shipment of the split sample, the commission shall confirm:

1. That the split sample laboratory has agreed to provide the testing requested;

2. That the split sample laboratory has agreed to send results to the commission; and

3. That arrangements for payment satisfactory to the split sample laboratory have been made.

(d) The commission shall maintain a list of laboratories approved for the testing of split samples and the list shall be on file

at the offices of the commission.

Section 13. Split Sample Chain of Custody. (1) Prior to opening the split sample freezer or refrigerator, the commission shall provide a split sample chain of custody verification form. The form to be used shall be the Split Sample Chain of Custody Form. The form shall be fully completed during the retrieval, packaging, and shipment of the split sample and shall contain the following information:

(a) The date and time the sample is removed from the split sample freezer or refrigerator;

(b) The sample number; and

(c) The address where the split sample is to be sent.

(2) A split sample shall be removed from the split sample freezer or refrigerator by a commission employee after notice to the owner, trainer, or designee, and a commission-designated representative shall pack the split sample for shipment in accordance with the packaging procedures directed by the commission. The Split Sample Chain of Custody Form shall be signed by both the owner's representative, if present, and the commission representative to confirm the proper packaging of the split sample for shipment. The exterior of the package shall be secured and sealed to prevent tampering with the package.

(3) The owner, trainer or designee, if present, may inspect the package containing the split sample immediately prior to transfer to the delivery carrier to verify that the package is intact and has not been tampered with.

(4) The Split Sample Chain of Custody Form shall be completed and signed by the representative of the commission and the owner, trainer or designee, if present.

(5) The commission representative shall retain the original Split Sample Chain of Custody Form and provide a copy for the owner, trainer, or designee, if requested.

Section 14. Medical Labeling. (1) A licensee on association grounds shall not have within his or her possession, or within his or her personal control, a drug, medication, or other substance that is prohibited from being administered to a horse on a race day unless the product is properly and accurately labeled.

(2) A drug or medication which, by federal or state law, requires a prescription shall not be used or kept on association grounds unless validly prescribed by a duly licensed veterinarian.

(3) A drug or medication shall bear a prescription label which is securely attached and clearly ascribed to show the following:

(a) The name of the product;

(b) The name, address and telephone number of the veterinarian prescribing or dispensing the product;

(c) The name of the horse for which the product is intended or prescribed;

(d) The dosage, duration of treatment and expiration date of the prescribed or dispensed product; and

(e) The name of the trainer to whom the product was dispensed.

Section 15. Trainer Responsibility. (1) A trainer shall be responsible for the condition of a horse in his or her care.

(2) A trainer shall be responsible for the presence of a prohibited drug, medication, substance, or metabolic derivative, including permitted medication in excess of the maximum allowable concentration, in a horse in his or her care.

(3) A trainer shall prevent the administration of a drug, medication, substance, or metabolic derivative that may constitute a violation of this administrative regulation.

(4) A trainer whose horse has been claimed shall remain responsible for a violation of this administrative regulation regarding that horse's participation in the race in which the horse is claimed.

(5) A trainer shall be responsible for:

(a) Maintaining the assigned stable area in a clean, neat and sanitary condition at all times;

(b) Using the services of those veterinarians licensed by the commission to attend to a horse that is on association grounds;

(c) The proper identity, custody, care, health, condition and safety of a horse in his or her care;

(d) Promptly reporting the alteration of the sex of a horse to the horse identifier and the racing secretary;

(e) Promptly reporting to the racing secretary and the commission veterinarian if a posterior digital neurectomy (heel nerving) is performed on a horse in his or her care and ensuring this fact is designated on its certificate of registration;

(f) Promptly reporting to the racing secretary the name of a mare in his or her care that has been bred and is entered to race;

(g) Promptly notifying the commission veterinarian of a reportable disease or communicable illness in a horse in his or her care;

(h) Promptly reporting the serious injury or death of a horse, in his or her care, at a location under the jurisdiction of the commission to the judges and the commission veterinarian and ensuring compliance with Section 22 of this administrative regulation governing postmortem examinations;

(i) Maintaining a medication record and medication status of a horse in his or her care;

(j) Promptly notifying the judges and the commission veterinarian if the trainer has knowledge or reason to believe that there has been an administration to a horse of a drug, medication, or other substance prohibited by this administrative regulation or has knowledge or reason to believe that a prohibited practice has occurred as set forth in Section 20 of this administrative regulation;

(k) Ensuring the fitness of every horse in his or her care to perform creditably at the distance entered;

(l) Ensuring proper bandages, equipment, and shoes;

(m) Ensuring the horse's presence in the paddock at least one (1) hour prior to post time, or at a time otherwise prescribed, by racing officials before the race in which the horse is entered;

(n) Personally attending in the paddock and supervising the preparation of a horse in his or her care, unless an assistant trainer fulfills these duties or the trainer is excused by the judges; and

(o) Attending the collection of a biologic specimen taken from a horse in his or her care or delegating a licensed employee or the owner to do so.

Section 16. Licensed Veterinarians. (1) A veterinarian licensed by the commission and practicing at a location under the jurisdiction of the commission shall be considered under the supervision of the commission veterinarian and the judges.

(2) A veterinarian shall report to the judges or the commission veterinarian a violation of this administrative regulation by a licensee.

Section 17. Veterinary Reports. (1) A veterinarian who treats a horse at a location under the jurisdiction of the commission shall submit a Veterinary Report of Horses Treated to be Submitted Daily form to the commission veterinarian containing the following information:

(a) The name of the horse treated;

(b) The type and dosage of drug or medication administered or prescribed;

(c) The name of the trainer of the horse;

(d) The date and time of treatment; and

(e) Other pertinent information requested by the commission veterinarian.

(2) The Veterinary Report of Horses Treated to be Submitted Daily form shall be signed by the treating veterinarian.

(3) The Veterinary Report of Horses Treated to be Submitted Daily form shall be on file not later than the time prescribed on the next race day by the commission veterinarian.

(4) The Veterinary Report of Horses Treated to be Submitted Daily form shall be confidential and its content shall not be disclosed except in the course of an investigation of a possible violation of this administrative regulation or in a proceeding before the judges or the commission, or to the trainer or owner of record at the time of treatment.

(5) A timely and accurate filing of a Veterinary Report of Horses Treated to be Submitted Daily form by the veterinarian or his or her designee that is consistent with the analytical results of a positive test reported by the commission laboratory may be used as a mitigating factor in determining the appropriate penalties

pursuant to 811 KAR 1:095.

(6) A veterinarian having knowledge or reason to believe that a horse entered in a race has received a drug, medication or substance prohibited under this administrative regulation or has knowledge or reason to believe that a prohibited practice has occurred as set forth in Section 20 of this administrative regulation shall report this fact immediately to the commission veterinarian or to the judges.

(7) A practicing veterinarian shall maintain records of all horses treated and of all medications sold or dispensed. The records shall include:

- (a) The name of the horse;
- (b) The trainer of the horse;
- (c) The date, time, amount and type of medication administered;
- (d) The drug or compound administered;
- (e) The method of administration; and
- (f) The diagnosis.

(8) The records shall be retained for at least sixty (60) days after the horse has raced and shall be available for inspection by the commission.

Section 18. Veterinarian's List. (1) The commission veterinarian shall maintain a list of horses determined to be unfit to compete in a race due to illness, physical distress, unsoundness, infirmity, or other medical condition.

(2) A horse may be removed from the veterinarian's list if, in the opinion of the commission veterinarian, the horse is capable of competing in a race.

(3) The commission veterinarian shall maintain a bleeder list of all horses that have demonstrated external evidence of exercise-induced pulmonary hemorrhage during or after a race or workout as observed by the commission veterinarian or a licensed veterinarian approved by the commission.

(4) A horse that is a confirmed bleeder, regardless of age, shall be placed on the bleeder list and be ineligible to participate in a race (betting or nonbetting), qualifying race, time trial, or official workout for the following time periods:

- (a) First incident - fourteen (14) days;
- (b) Second incident within a 365 day period - thirty (30) days;
- (c) Third incident within a 365 day period - 180 days; and
- (d) Fourth incident within a 365 day period - barred from racing for life.

(5) For the purpose of counting the number of days a horse is ineligible to run, the day after the horse bled externally shall be the first day of the recovery period.

(6) The voluntary administration of furosemide without an external bleeding incident shall not subject a horse to the initial period of ineligibility as defined in this section.

(7) A horse that has been placed on a bleeder list in another jurisdiction may be placed on the bleeder list maintained by the commission veterinarian.

Section 19. Distribution of Purses, Barn Searches, and Retention of Samples. (1) Purse money shall be distributed no later than twenty-four (24) hours after notice from the commission that a final laboratory report has been issued.

(2) The distribution of purse money prior to the issuance of a final laboratory report shall not be considered a finding that no prohibited drug, medication, substance, or metabolic derivative has been administered to a horse.

(3) After the laboratory issues a positive finding, the executive director of the commission or the judges shall immediately authorize and execute an investigation into the circumstances surrounding the incident that is the subject of the positive finding.

(4) At the conclusion of the investigation, a report shall be prepared and filed with the executive director and chairman of the commission detailing the findings of the investigation.

(5) If the purse money has been distributed, the judges shall order the money returned at the conclusion of an investigation finding that a prohibited drug, medication, substance, or metabolic derivative was administered to a horse eligible for purse money.

(6) At the conclusion of testing by the commission laboratory

and split sample laboratory, the remaining portion of the samples at the commission laboratory and split samples remaining at the test barn may be retained at a proper temperature at a secure facility approved and chosen by the commission. If a report indicating a positive finding has been issued, the commission shall use its best reasonable efforts to retain any remaining portion of the sample until legal proceedings have concluded. The commission may freeze samples.

Section 20. Other Prohibited Practices. (1) A drug, medication, or substance shall not be possessed or used by a licensee, or his designee or agent, within a nonpublic area at a location under the jurisdiction of the commission:

(a) The use of which may endanger the health and welfare of the horse; or

(b) The use of which may endanger the safety of the driver.

(2) Without the prior permission of the commission or its designee, a drug, medication or substance that has never been approved by the United States Food and Drug Administration (USFDA) for use in humans or animals shall not be possessed or used at a location under the jurisdiction of the commission. The commission shall determine whether to grant prior permission after consultation with the Equine Drug Research Council.

(3) The following blood doping agents shall not be possessed or used at a location under the jurisdiction of the commission:

- (a) Erythropoietin;
- (b) Darbepoetin;
- (c) Oxyglobin®;
- (d) Hemopure®; or
- (e) Any substance that abnormally enhances the oxygenation of body tissue.

(4) A treatment, procedure or therapy shall not be practiced, administered, or applied which may:

- (a) Endanger the health or welfare of a horse; or
- (b) Endanger the safety of a driver.

(5) Extracorporeal shock wave therapy or radial pulse wave therapy shall not be used unless the following conditions are met:

- (a) A treated horse shall not race for a minimum of ten (10) days following treatment;
- (b) A veterinarian licensed to practice by the commission shall administer the treatment;

(c) The commission veterinarian shall be notified prior to the delivery of the machine on association grounds; and

(d) A report shall be submitted by the veterinarian administering the treatment to the commission veterinarian on the Kentucky Horse Racing Commission Veterinary Report of Horses Treated with Extracorporeal Shock Wave Therapy form within twenty-four (24) hours of treatment.

(6) Other than furosemide, an alkalinizing substance that could alter the blood serum or plasma pH or concentration of bicarbonates or carbon dioxide in a horse shall not be used within twenty-four (24) hours prior to post time of the race in which the horse is entered.

(7) Without the prior permission of the commission veterinarian or his designee, based on standard veterinary practice for recognized conditions, a nasogastric tube which is longer than six (6) inches shall not be used for the administration of any substance within twenty-four (24) hours prior to post time of the race in which the horse is entered.

(8) A blood serum or plasma total carbon dioxide (TCO2) level shall not exceed 37.0 millimoles per liter in a horse to which furosemide has not been administered, or 39.0 millimoles per liter in a horse to which furosemide has been administered; except, no violation shall exist if the TCO2 level is found to be normal for the horse following the quarantine procedure set forth in Section 21 of this administrative regulation.

(9) A blood gas machine shall not be possessed or used by a person other than an authorized representative of the commission at a location under the jurisdiction of the commission.

(10) A shock wave therapy machine or radial pulse wave therapy machine shall not be possessed or used by anyone other than a veterinarian licensed by the commission at a location under the jurisdiction of the commission.

Section 21. TCO2 Testing and Procedures. (1)(a) The presiding judge may order the pre-race or post-race collection of blood specimens from, and pre-race or post-race testing of, a horse to determine the total carbon dioxide concentration in the blood serum or plasma of the horse. The winning horse and other horses, as directed by the presiding judge, may be tested in each race to determine if there has been a violation of this administrative regulation.

(b) Pre-race and post-race testing shall be done at a reasonable time, place, and manner as directed by the presiding judge in consultation with the commission veterinarian.

(c) A specimen consisting of at least two (2) blood tubes shall be taken from a horse to determine the TCO2 concentration in the blood serum or plasma of the horse. If the commission laboratory determines that the TCO2 exceeds 37.0 millimoles per liter in a horse to which furosemide has not been administered, or 39.0 millimoles per liter in a horse to which furosemide has been administered, the executive director of the commission shall be informed of the positive finding.

(d) If the specimen is taken prior to the race and the TCO2 exceeds 37.0 millimoles per liter in a horse to which furosemide has not been administered, or 39.0 millimoles per liter in a horse to which furosemide has been administered, the judges shall scratch the horse from the race.

(e) Split sample testing for TCO2 may be requested by an owner or trainer in advance of the collection of the specimen by the commission veterinarian; however, the collection and testing of a split sample for TCO2 testing shall be done at a reasonable time, place and manner directed by the commission veterinarian.

(f) The cost of split sample testing, including the cost of shipping, shall be borne by the owner or the trainer.

(2)(a) If the level of TCO2 is determined to exceed 37.0 millimoles per liter in a horse to which furosemide has not been administered, or 39.0 millimoles per liter in a horse to which furosemide has been administered, and the licensed owner or trainer of the horse certifies in writing to the judges within twenty-four (24) hours after the notification of the test result that the level is normal for that horse, the owner or trainer may request that the horse be held in quarantine. If quarantine is requested, the licensed association shall make guarded quarantine available for that horse for a period of time to be determined by the judges but not for more than 120 hours.

(b) The expense for maintaining the quarantine shall be borne by the owner or trainer.

(c) During quarantine, the horse shall be re-tested periodically by the commission veterinarian.

(d) The horse shall not be permitted to race during a quarantine period, but it may be exercised and trained at times prescribed by the licensed association and in a manner that allows monitoring of the horse by a commission representative.

(e) During quarantine, the horse shall be fed only hay, oats, water, and, subject to the specific approval of the commission veterinarian, the horse's usual feed ration and supplements. In addition, subject to approval of the commission veterinarian, the horse shall be administered furosemide by the commission veterinarian in the same manner and at the same dosage as was provided to horses eligible for furosemide on the day which the horse in quarantine raced.

(f) If the commission veterinarian is satisfied that the horse's level of TCO2, as registered in the original test, is physiologically normal for that horse, the judges:

1. Shall permit the horse to race; and

2. May require repetition of the quarantine procedure set forth in paragraphs (a) through (f) of this subsection to reestablish that the horse's TCO2 level is physiologically normal.

Section 22. Postmortem Examination. (1) A horse that dies or is euthanized on the grounds of a licensed association or training center under the jurisdiction of the commission shall undergo a postmortem examination at the discretion of the commission and at a facility designated by the commission, through its designee, as provided in 810 KAR 1:012, Section 14.

(2) The commission shall bear the cost of an autopsy that is

required by the commission.

(3) The presence of a prohibited drug, medication, substance or metabolic derivative thereof in a specimen collected during the postmortem examination of a horse that died during a pari-mutuel race shall constitute a violation of this administrative regulation.

Section 23. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Veterinary Report of Horses Treated to be Submitted Daily", KRC-2, 8/97;

(b) "Split Sample Chain of Custody Form", KHRC 18-01, 4/12;

(c) "Veterinary Report of Horses Treated with Extracorporeal Shock Wave Therapy", KHRC 18-02, 4/12; and

(d) "Therapeutic AAS Administration Form", KHRC 18-03, 4/12.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Horse Racing Commission, 4063 Iron Works Parkway[Pike], Building B, Lexington, Kentucky 40511, Monday through Friday, 8:00 a.m. to 4:30 p.m. This material is also available on the commission's Web site at <http://khrc.ky.gov>.

ROBERT M. BECK, Jr., Chairman

ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: December 30, 2013

FILED WITH LRC: January 10, 2014 at 2 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014 at 10:00 a.m., at the offices of the Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511. Individuals interested in being heard at this hearing shall notify the Kentucky Horse Racing Commission in writing by February 18, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be 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 February 28, 2014. Please send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

CONTACT PERSON: Susan B. Speckert, General Counsel, Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511, phone (859) 246-2040, fax (859) 246-2039.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Susan B. Speckert

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation governs the administration of drugs, medications, and substances to standardbred horses racing at licensed racing associations in Kentucky. It identifies both permitted and prohibited substances and establishes protocols for the administration of the permitted substances. It establishes procedures for the collection, storage, and shipment of biologic specimens that will be tested for regulated substances, as well as the chain of custody and testing protocols for those biologic specimens. The administrative regulation defines a trainer's responsibilities, making the trainer responsible for the condition of any horse in his or her care. It establishes reporting requirements for veterinarians who are treating racehorses in Kentucky and creates a Veterinarian's List, which documents all horses that the commission veterinarian determines to be unfit for racing. Finally, it establishes procedures for the post-mortem examination of horses that die or are euthanized on the grounds of a licensed racing association or training center under the jurisdiction of the commission.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to fulfill the statutory mandates found in KRS 230.215(2) and KRS 230.240(2). KRS 230.215(2) states that, [I]t is hereby declared the purpose and intent of this chapter in the interest of the public health, safety, and welfare, to vest in the racing commission forceful control of horse racing in the Commonwealth with plenary power to promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth...KRS 230.240(2) states that, The racing commission shall promulgate administrative regulations for effectively preventing the use of improper devices, and restricting or prohibiting the use and administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. The racing commission may acquire, operate, and maintain, or contract for the maintenance and operation of, a testing laboratory and related facilities, for the purpose of saliva, urine, or other tests, and to purchase supplies and equipment for and in connection with the laboratory or testing processes... Without this administrative regulation, the commission would be unable to effectively fulfill the statutory mandates set forth above.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 230.215(2) mandates that the commission establish the conditions under which horse racing and pari-mutuel wagering thereon shall be conducted in Kentucky and charges it to, "promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth." KRS 230.240(2) further requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation both identifies regulated substances and establishes protocols by which the commission can collect biologic specimens from horses and test those specimens for drugs or stimulants. In so doing, it allows the commission to "maintain horse racing at horse race meetings in the Commonwealth of the highest quality and free of any corrupt, incompetent, dishonest, or unprincipled horse racing practices, and to regulate and maintain horse racing at race meetings in the Commonwealth so as to dissipate any cloud of association with the undesirable and maintain the appearance as well as the fact of complete honesty and integrity of horse racing in the Commonwealth." See KRS 230.215.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: KRS 230.215 requires the commission to regulate horse racing in Kentucky "free of any corrupt, incompetent, dishonest, or unprincipled horse racing practices, and to regulate and maintain horse racing at race meetings in the Commonwealth so as to dissipate any cloud of association with the undesirable and maintain the appearance as well as the fact of complete honesty and integrity of horse racing in the Commonwealth." KRS 230.240 requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation provides the specific policies, prohibitions, protocols, and procedures necessary to fulfill the statutory mandates set forth in KRS 230.215 and KRS 230.240. It also provides notice to owners and trainers regarding what medications and practices are, or are not, permitted.

(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 changes to the administrative regulation are based on current medical research and make the standardbred medication regulation consistent with the medication regulation for Thoroughbreds and quarter horse, Appaloosas and Arabians.

(b) The necessity of the amendment to this administrative regulation: The landscape of horse racing – as it pertains to the use of stimulants, drugs and other improper substances – is constantly changing and the commission must periodically amend its administrative regulations to keep pace with these developments. This amendment reflects industry-wide policy

changes and is necessary to ensure that the commission's regulatory framework accounts for recent developments in medical science.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 230.215(2) grants the commission the authority to regulate conditions under which horse racing and pari-mutuel wagering thereon shall be conducted in Kentucky and charges it to, "promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth." KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This amendment specifically addresses the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race in Kentucky.

(d) How the amendment will assist in the effective administration of the statutes: The amendment allows the commission to keep pace with developments in the medical and pharmaceutical industries. It also ensures that Kentucky's regulatory framework is consistent with industry wide trends in this area which results in greater uniformity of rules among various racing jurisdictions.

(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 many of the commission's licensees, either directly or indirectly, including owners, trainers and their employees, veterinarians, drivers, racing associations and their employees, and the commission itself. It will directly affect owners, trainers and veterinarians, who will have to comply with the amended administrative regulation. It will affect the commission, which is charged with administering and enforcing the rules. It will affect the commission's official laboratory, which will be required to perform and report testing consistent with the amendment. It will indirectly affect the racing associations and wagering patrons, who will have increased confidence that standardbred racing in Kentucky is "free of any corrupt, incompetent, dishonest, or unprincipled horse racing practices." It will affect drivers, grooms, and any other persons who have direct contact with the racehorses, in that the amendment provides a strong deterrent to putting their health, safety, and welfare at risk through the use of prohibited substances.

(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 owners and trainers and practicing veterinarians will be required to conform their practices to the amended administrative regulation. The commission will be responsible for enforcing the amendments to the medication rules. The remainder of the entities identified in question (3) will not be required to take any action 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): The owners and trainer will likely not bear any additional expenses as a result of this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Each of the entities will benefit from more consistent and uniform rules based on medical science.

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

(a) Initially: There will be no cost to implement this administrative regulation.

(b) On a continuing basis: There will be no cost on a continuing basis to enforce this administrative regulation.

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

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: The administrative regulation does not establish any fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied. All aspects of this administrative regulation will be applied equally to the affected parties.

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 Horse Racing Commission.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. Kentucky Revised Statutes 230.215, 230.225, 230.260, 230.290, 230.310, 230.320.

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? The amendment will not result in any additional costs to the commission.

(d) How much will it cost to administer this program for subsequent years? The amendment will not result in any additional costs to the commission.

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:

PUBLIC PROTECTION CABINET Kentucky Horse Racing Commission (Amendment)

811 KAR 1:093. Drug, medication, and substance classification schedule and withdrawal guidelines.

RELATES TO: KRS 230.210, 230.215, 230.240, 230.260, 230.265, 230.290, 230.320

STATUTORY AUTHORITY: KRS 230.215, 230.240, 230.260, 230.320

NECESSITY, FUNCTION, AND CONFORMITY: KRS 230.215(2) authorizes the Kentucky Horse Racing Commission to promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in Kentucky. KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation establishes the drug classification schedule in effect in Kentucky and the withdrawal guidelines for permitted drugs, medications, and substances that may be administered to race horses competing in Kentucky.

Section 1. The Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule, KHRC

40-01, shall establish the respective classifications of all substances contained therein. The Kentucky Horse Racing Commission Withdrawal Guidelines Standardbred, KHRC 93-01, shall provide certain mandatory treatment requirements and guidance and advice on withdrawal intervals as contained therein.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule," KHRC 40-01, December 2013[April 2012]; and

(b) "Kentucky Horse Racing Commission Withdrawal Guidelines Standardbred", [] KHRC 93-01, December 2013[April 2012].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Horse Racing Commission, 4063 Iron Works[Ironworks] Parkway, Building B, Lexington, Kentucky 40511, Monday through Friday, 8:00 a.m. to 4:30 p.m., or on the commission's [commission] Web site at <http://khrc.ky.gov>.

ROBERT M. BECK, Jr., Chairman

ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: December 30, 2013

FILED WITH LRC: January 10, 2014 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014 at 10:00 a.m., at the offices of the Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511. Individuals interested in being heard at this hearing shall notify the Kentucky Horse Racing Commission in writing by February 18, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be 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 February 28, 2014. Please send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

CONTACT PERSON: Susan B. Speckert, General Counsel, Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511, phone (859) 246-2040, fax (859) 246-2039.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Susan B. Speckert

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation incorporates the Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule (the "Schedule") and the Kentucky Horse Racing Commission Withdrawal Guidelines Standardbred (the "Withdrawal Guidelines") by reference. Both documents are affected by scientific research and, thus, should be amended and updated on an ongoing basis based on developments in medical science. The Schedule establishes a classification system of regulated substances, and those classifications are then used to determine the appropriate penalty if there is a violation of 811 KAR 1:090 or 811 KAR 1:240. Thus, the Schedule provides notice to licensees regarding the potential penalty for use of a certain substance. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances. This amendment adds one substance to the list of Class A drugs contained in the Schedule. The amendment also makes certain changes to the Withdrawal Guidelines based on recommendations from the Racing Medication and Testing Consortium ("RMTTC") and to make the Standardbred Guidelines

consistent with the Thoroughbred and Quarter Horse, Appaloosa, and Arabian Guidelines. The RMTC is a national organization dedicated to the development, promotion, and coordination of policies, research, and educational programs that seek to ensure the fairness and integrity of horse racing and the health and welfare of racehorses and its participants at the national level. The RMTC developed regulatory thresholds and withdrawal guidance for 24 therapeutic medications having legitimate and conventional use in the care of racehorses of all breeds. The 24 thresholds and withdrawal times are the result of a rigorous scientific process involving medication administrations to horses, serial sample collections, and statistical analysis of the resultant data. The other changes are to make the Standardbred Guidelines consistent with the Thoroughbred and Quarter Horse, Appaloosa, and Arabian Guidelines. The Withdrawal Guidelines are conservative and intended to produce a substantial margin of safety so that ethical veterinary care can be provided to racehorses without fear of violating Kentucky's medication regulations. These thresholds and withdrawal guidelines have been adopted, or are under consideration, in multiple other racing jurisdictions. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing. Industry stakeholders have long maintained that uniformity is both desirable and necessary for fair competition.

(b) The necessity of this administrative regulation: The Schedule puts licensees on notice of how various regulated substances are classified. The classifications, in turn, dictate the penalties that will be levied if the substance in question is administered in violation of 811 KAR 1:090 or 811 KAR 1:240. The Withdrawal Guidelines are necessary to provide guidance to licensees regarding the regulated administration of certain medications and other substances prior to a horse competing in a race in Kentucky. The amendments are based on developments in medical science and represent a major step towards national uniformity in medication regulation and drug testing.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 230.215(2) mandates that the commission establish the conditions under which horse racing and pari-mutuel wagering thereon shall be conducted in Kentucky and charges it to, "promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth." KRS 230.240(2) further requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. The Schedule classifies regulated substances to give notice to licensees and to allow the commission to levy the appropriate penalty in the event of a violation. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The Schedule classifies regulated substances, thereby providing notice to licensees and allowing the commission to levy the appropriate penalty in the event of a violation of 811 KAR 1:090 or 811 KAR 1:240. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances.

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

(a) How the amendment will change this existing administrative regulation: This amendment adds one substance to the list of Class A drugs contained in the Schedule. The amendment also makes certain changes to the Withdrawal Guidelines based on recommendations from the RMTC and to make the Standardbred Guidelines consistent with the Thoroughbred and Quarter Horse, Appaloosa, and Arabian Guidelines. The RMTC developed regulatory thresholds and withdrawal guidance for 24 therapeutic medications having legitimate and conventional use in the care of racehorses of all breeds. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing.

(b) The necessity of the amendment to this administrative

regulation: The amendments are based on current scientific research and represent a major step towards national uniformity in medication regulation and drug testing.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to the Schedule will insure that the commission regulates the use of medication and other substances in racehorses in a manner that is consistent with the latest developments in medical science. The Withdrawal Guidelines provide guidance to licensees on administration of certain regulated substances.

(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 licensed owners, trainers and veterinarians. It will also affect the commission as it regulates the use of medication and other substances on horses competing 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: Licensees should take notice of the classifications provided in the Schedule and should follow the recommendations given in the Withdrawal Guidelines. The commission will use the Schedule to determine the appropriate penalties for violations of 811 KAR 1:090 or 811 KAR 1:240 and take into consideration compliance with the Withdrawal Guidelines when imposing a penalty.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Compliance with this administrative regulation will not result in any additional costs to any of the entities identified in question (3).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Licensees and the commission will benefit from the updates included in the Schedule and Withdrawal Guidelines because the updates reflect developments in medical science. In addition, these thresholds and withdrawal guidelines have been adopted, or are under consideration, in multiple other racing jurisdictions. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing. Industry stakeholders have long maintained that uniformity is both desirable and necessary for fair competition.

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

(a) Initially: There are no anticipated costs to the commission.

(b) On a continuing basis: There are no anticipated costs to the commission.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: There is no additional funding necessary to implement or enforce the amendments to 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 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 or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied. All aspects of this administrative regulation will be applied equally to the affected parties.

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 Horse Racing Commission.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 230.210, 230.215, 230.240, 230.260, 230.265, 230.290, 230.320.

(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 will have no effect on expenditures or revenues.

(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 costs associated with the implementation of the amendments to this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? There will be no costs associated with the implementation of the amendments to this administrative regulation.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

**PUBLIC PROTECTION CABINET
Kentucky Horse Racing Commission
(Amendment)**

811 KAR 1:095. Disciplinary measures and penalties.

RELATES TO: KRS 230.215, 230.260, 230.265, 230.290, 230.300, 230.320

STATUTORY AUTHORITY: KRS 230.215, 230.240, 230.260, 230.320

NECESSITY, FUNCTION, AND CONFORMITY: KRS 230.215(2) and 230.260(8) authorize the commission to promulgate administrative regulations prescribing the conditions under which horse racing shall be conducted in Kentucky. KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the use and administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation establishes the disciplinary powers and duties of the judges and the commission.

Section 1. Definitions. (1) "Associated person" means the spouse of an inactive person, or a companion, family member, employer, employee, agent, partnership, partner, corporation or other entity whose relationship, whether financial or otherwise, with an inactive person would give the appearance that the other person or entity would care for or train a horse, or perform veterinarian services on a horse for the benefit, credit, reputation, or satisfaction of the inactive person.

(2) "Class A drug" means a drug, medication, or substance classified as a Class A drug, medication, or substance in the schedule.

(3) "Class B drug" means a drug, medication, or substance classified as a Class B drug, medication, or substance in the

schedule.

(4) "Class C drug" means a drug, medication, or substance classified as a Class C drug, medication, or substance in the schedule.

(5) "Class D drug" means a drug, medication, or substance classified as a Class D drug, medication, or substance in the schedule.

(6) "Companion" means a person who cohabits with or shares living accommodations with an inactive person.

(7) "Inactive person" means a trainer or veterinarian who has his or her license denied or suspended or revoked for thirty (30) or more days pursuant to 811 KAR Chapter 1 or KRS Chapter 230.

(8) "NSAID" means a non-steroidal anti-inflammatory drug.

(9) "Primary threshold" means the thresholds for phenylbutazone, flunixin, and ketoprofen provided in 811 KAR 1:090, Section 8(2)(c), (3)(c), and (4)(c), respectively.

(10) "Schedule" means the Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule as provided in 811 KAR 1:093.

(11) "Secondary threshold" means the thresholds for phenylbutazone and flunixin provided in 811 KAR 1:090, Section 8(6)(b) and (c).

(12) "Withdrawal guidelines" means the Kentucky Horse Racing Commission Withdrawal Guidelines Standardbreds as provided in 811 KAR 1:093.

Section 2. General Provisions. (1) An alleged violation of 811 KAR 1:090 shall be adjudicated in accordance with this administrative regulation, and with 811 KAR 1:100, 811 KAR 1:105, and KRS Chapter 13B.

(2) If a drug, medication, or substance is found to be present in a pre-race or post-race sample or possessed or used by a licensee at a location under the jurisdiction of the commission that is not classified in the schedule, the commission may establish a classification after consultation with either or both of the Association of Racing Commissioners International and the Racing and Medication Consortium or their respective successors.

(3) The judges and the commission shall consider any mitigating or aggravating circumstances properly presented when assessing penalties pursuant to this administrative regulation. Evidence of full compliance with the withdrawal guidelines shall be considered by the judges and the commission as a mitigating factor to be used in determining violations and penalties.

(4) Pursuant to KRS 230.320, the commission may suspend or revoke the commission-issued license of an owner, trainer, veterinarian, or other licensee.

(5) A licensee whose license has been suspended or revoked in any racing jurisdiction or a horse that has been deemed ineligible to race in any racing jurisdiction shall be denied access to locations under the jurisdiction of the commission during the term of the suspension or revocation.

(6) A suspension or revocation shall be calculated in calendar days, unless otherwise specified by the judges or the commission in a ruling or order.

(7) Written or printed notice of the assessment of a penalty, including a written warning, shall be made to the person penalized. The notice shall be posted immediately at the office of the association and sent to the commission, the United States Trotting Association, and the Association of Racing Commissioners International, or their successors, to be posted on their respective official Web sites. If an appeal is pending, that fact shall be so noted.

(8) A horse administered a substance in violation of 811 KAR 1:090 may be required to pass a commission-approved examination pursuant to 811 KAR 1:020, Section 5, or be placed on the veterinarian's list pursuant to 811 KAR 1:090, Section 18.

(9) A person who claims a horse may void the claim if the post-race test indicates a Class A, B, or C drug violation, or a TCO2 level exceeding thirty-seven (37.0) millimoles per liter and receive reimbursement for reasonable costs associated with the claim as provided in 811 KAR 1:035, Section 3(14)(a)(3).

(10) To protect the racing public and ensure the integrity of racing in Kentucky, a trainer whose penalty for a prior Class A

violation or for a prior Class B third offense violation under this administrative regulation has not been finally adjudicated may, if stall space is available, be required to house a horse that the trainer has entered in a race in a designated stall for the twenty-four (24) hour period prior to post time of the race in which the horse is entered. If the judges require the trainer's horse to be kept in a designated stall, there shall be twenty-four (24) hour surveillance of the horse by the association and the cost shall be borne by the trainer.

(11) A veterinarian who has engaged in prohibited practices in violation of 811 KAR 1:090 shall be reported to the Kentucky Board of Veterinary Examiners and the state licensing board of veterinary medicine by the judges.

(12) An administrative action or the imposition of penalties pursuant to this administrative regulation shall not constitute a bar or be considered jeopardy to prosecution of an act that violates the criminal statutes of Kentucky.

(13) If a person is charged with committing multiple or successive overages involving a Class C or Class D drug, medication, or substance, the judges or the commission may charge the person with only one (1) offense if the person demonstrates that he or she was not aware that overages were being administered because the positive test results showing the overages were unavailable to the person charged. In this case, the person alleging that he or she was not aware of the overages shall bear the burden of proving that fact to the judges or the commission.

(14) Any person who has been fined under this administrative regulation shall be suspended until the fine has been paid in full.

(15) A fine shall not be paid directly or indirectly by a person other than the person upon whom it is imposed and any payment made shall not serve to abate or satisfy any penalty imposed.

(16) Written or printed notice of the assessment of a penalty shall be made to the person penalized, notice shall be posted immediately at the office of the association, and notice shall be forwarded immediately to the office of the commission, the United States Trotting Association, and the Association of Racing Commissioners International by the presiding judge or clerk of the course.

(17) If the penalty is for a driving violation and does not exceed in time a period of five (5) days, the driver may complete the engagement of all horses declared in before the penalty becomes effective. The driver may drive in stake, futurity, early closing and feature races, during a suspension of five (5) days or less, but the suspension shall be extended one (1) day for each date the driver drives in a race.

(18) A horse shall not have the right to compete while owned or controlled wholly or in part by a person whose license has been suspended or revoked. An entry made by or for a licensee whose license has been suspended or revoked or for a horse which has been suspended shall be held liable for the entrance fee without the right to compete unless the penalty is removed.

(19) An association shall not willfully allow a person whose license has been suspended or revoked to drive in a race, or a suspended or disqualified horse to start in a race or a performance against time.

(20) An association shall not willfully allow the use of its track or grounds by a licensee whose license has been suspended or revoked, or a horse that has been suspended.

(21) If a person is excluded from a pari-mutuel association by the association, the commission shall be notified.

(22) A person subject to current suspension, revocation, or expulsion shall not act as an officer of an association. An association shall not, after receiving notice of the penalty, employ or retain in its employ an expelled, suspended, disqualified, or excluded person at or on the track during the progress of a race meeting.

(23) A licensee that has been suspended shall serve any suspension imposed:

(a) During the current race meet, if there are enough remaining days to serve out the suspension;

(b) During the next regularly scheduled race meet at the operating race track where the infraction took place if there are not

enough remaining days to serve out the suspension; or

(c) During a race meet at another operating track in this state where the licensee seeks to engage in the activity for which he or she is licensed if the track where the infraction took place closes before another race meet is held at that track.

(24) A penalty imposed by the United States Trotting Association or the racing commission, or other governing body, of any racing jurisdiction shall be recognized and enforced by the commission unless application is made for a hearing before the commission, during which the applicant shall show cause as to why the penalty should not be enforced against him in Kentucky.

Section 3. Prior Offenses. A prior offense occurring in Kentucky or any other racing jurisdiction shall be considered by the judges and by the commission in assessing penalties. The judges shall attach to a penalty judgment a copy of the offender's prior record listing violations that were committed both inside and outside of Kentucky.

Section 4. Penalties for Violations Not Related To Drugs or Medications. (1) A licensee who commits a violation classified as a Category 1 violation shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(a) A suspension or revocation of licensing privileges from zero days to thirty (30) days; and

(b) Payment of a fine not to exceed \$5,000.

(2) A licensee who commits a violation classified as a Category 2 violation shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(a) A suspension or revocation of licensing privileges from thirty (30) days to sixty (60) days; and

(b) Payment of a fine not to exceed \$10,000.

(3) A licensee who commits a violation classified as a Category 3 violation shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(a) A suspension or revocation of licensing privileges from sixty (60) days to permanent suspension or revocation; and

(b) Payment of a fine up to \$50,000.

(4) A violation of 811 KAR Chapter 1 not otherwise specifically addressed shall be a Category 1 violation and shall be subject to the penalties set forth in subsection (1) of this section.

Section 5. Penalties for Violations Relating to Class A, B, C, or D Drugs. (1) Class A drug. A horse that tests positive for a Class A drug shall be disqualified and listed as unplaced and all purse money shall be forfeited. In addition, a licensee who administers, or is a party to or responsible for administering a Class A drug to a horse, shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(a) For a first offense:

1. A minimum one (1) year suspension, absent mitigating circumstances. The presence of aggravating factors may be used to impose a maximum of a three (3) year suspension or revocation. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$5,000 to \$10,000.

(b) For a second offense:

1. A minimum three (3) year suspension or revocation, absent mitigating circumstances. The presence of aggravating factors may be used to impose a maximum of a five (5) year suspension or revocation. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$10,000 to \$20,000.

(c) For a third lifetime offense in any racing jurisdiction:

1. A minimum five (5) year suspension or revocation, absent mitigating circumstances. The presence of aggravating factors may be used to impose a maximum of a lifetime revocation. Section 9 of this administrative regulation shall apply to any person whose

licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$20,000 to \$50,000.

(d) Horse ineligible. A horse that tests positive for a Class A drug shall be ineligible to race in Kentucky as follows:

1. For a first offense, the horse shall be ineligible from zero days to sixty (60) days;

2. For a second offense in a horse owned by the same owner, the horse shall be ineligible from sixty (60) days to 180 days; and

3. For a third offense in a horse owned by the same owner, the horse shall be ineligible from 180 days to 240 days.

(2) Class B drug. A horse that tests positive for a Class B drug shall be disqualified and listed as unplaced and all purse money shall be forfeited. In addition a licensee who administers, or is a party to or is responsible for administering a Class B drug to a horse shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(a) For a first offense:

1. A minimum fifteen (15) day suspension, absent mitigating circumstances. The presence of aggravating factors may be used to impose a maximum of a sixty (60) day suspension. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$500 to \$1,000.

(b) For a second offense within a 365-day period in any racing jurisdiction:

1. A minimum sixty (60) day suspension, absent mitigating circumstances. The presence of aggravating factors may be used to impose a maximum of a 180 day suspension. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$1,000 to \$2,500.

(c) For a third offense within a 365-day period in any racing jurisdiction:

1. A minimum 180 day suspension, absent mitigating circumstances. The presence of aggravating factors may be used to impose a maximum of a one (1) year suspension. Section 9 of this administrative regulation shall apply to the person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$2,500 to \$5,000.

(d) Horse ineligible. A horse that tests positive for a Class B drug shall be ineligible to race in Kentucky as follows:

1. For a first offense, the horse shall be ineligible from zero days to sixty (60) days;

2. For a second offense in a horse owned by the same owner, the horse shall be ineligible from sixty (60) days to 180 days; and

3. For a third offense in a horse owned by the same owner, the horse shall be ineligible from 180 days to 240 days.

(3) Class C drug or overage of either permitted NSAID flunixin or ketoprofen.

(a) The following licensees shall be subject to the penalties in paragraphs (b) through (d) of this subsection as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

1. A licensee who administers, or is a party to or responsible for administering a Class C drug to a horse, in violation of 810 KAR 1:090; and

2. A licensee who is responsible for an overage of either permitted NSAID flunixin or ketoprofen in the following concentrations in violation of 811 KAR 1:090:

a. Flunixin, greater than 100 ng/ml; or

b. Ketoprofen, greater than fifty (50) ng/ml.

(b) For a first offense:

1. A suspension or revocation of licensing privileges from zero days to ten (10) days;

2. Payment of a fine of \$250 to \$500; and

3. Forfeiture of purse money won.

(c) For a second offense within a 365-day period:

1. A suspension or revocation of licensing privileges from ten (10) days to thirty (30) days;

2. Payment of a fine of \$500 to \$1,000; and

3. Forfeiture of purse money won.

(d) For a third offense within a 365-day period:

1. A suspension or revocation of licensing privileges from thirty (30) days to sixty (60) days;

2. Payment of a fine of \$1,000 to \$2,500; and

3. Forfeiture of purse money won.

(e) Notwithstanding paragraphs (a) through (d) of this subsection, a licensee who administers, or is a party to or responsible for an overage of either permitted NSAID flunixin or ketoprofen in the following concentrations shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

1. Flunixin (21-99 ng/ml); or

2. Ketoprofen (11-49ng/ml).

a. For a first offense:

(i) A suspension or revocation of licensing privileges from zero days to five (5) days; and

(ii) Payment of a fine of \$250 to \$500.

b. For a second offense within a 365-day period:

(i) A suspension or revocation of licensing privileges from five (5) days to ten (10) days; and

(ii) Payment of a fine of \$500 to \$1,000.

c. For a third offense within a 365-day period:

(i) A suspension or revocation of licensing privileges from ten (10) days to fifteen (15) days.

(ii) Payment of a fine of \$1,000 to \$2,500; and

(iii) Forfeiture of purse money won.

(4) Overage of Permitted NSAID Phenylbutazone.

(a) A licensee who administers, or is a party to or responsible for an overage of the permitted NSAID phenylbutazone in a concentration of greater than two (2.0) mcg/ml and less than 5.1 mcg/ml shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

1. For a first offense:

a. Minimum penalty of a written warning up to a maximum penalty of a \$500 fine; and

b. The horse may not be eligible to enter until it has been approved for racing by the commission veterinarian.

2. For a second offense within a 365-day period:

a. Minimum penalty of a written warning up to a maximum penalty of a \$750 fine; and

b. The horse shall not be eligible to enter until it has been approved for racing by the commission veterinarian.

3. For a third offense within a 365-day period:

a. A fine of \$500 to \$1,000;

b. Forfeiture of purse money won;

c. The horse shall be disqualified and listed as unplaced; and

d. The horse shall not be eligible to enter until it has been approved for racing by the commission veterinarian.

(b) A licensee who administers, or is a party to or responsible for an overage of the permitted NSAID Phenylbutazone in a concentration of greater than five (5.0) mcg/ml shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

1. For a first offense, payment of a fine from \$1,000 to \$1,500; and

2. For a second offense within a 365-day period:

a. Payment of a fine from \$1,500 to \$2,500;

b. A suspension of licensing privileges for fifteen (15) days, unless the stewards or the commission finds mitigating circumstances;

c. Forfeiture of purse money won; and

d. The horse shall be disqualified and listed as unplaced.

3. For a third offense within a 365-day period:

a. A fine of \$2,500 to \$5,000;

b. A suspension of licensing privileges for thirty (30) days, unless the stewards or the commission finds mitigating circumstances;

c. Forfeiture of purse money won; and

d. The horse shall be disqualified and listed as unplaced[Class C drug. A licensee who administers, or is a party to or is responsible for administering a Class C drug to a horse or an

overage of a permitted NSAID shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(a) For a first offense:

1. A suspension or revocation of licensing privileges from zero days to ten (10) days. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$250 to \$500.

(b) For a second offense within a 365-day period:

1. A suspension or revocation of licensing privileges from ten (10) days to thirty (30) days. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$500 to \$1,000.

(c) For a third offense within a 365-day period:

1. A suspension or revocation of licensing privileges from thirty (30) days to sixty (60) days. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

2. Payment of a fine of \$1,000 to \$2,500.

(5)[(4)] Multiple NSAIDs. A licensee who is responsible for an overage of two (2) of the permitted NSAIDs flunixin, ketoprofen, or phenylbutazone shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(a) For violations where the concentrations of both of the two (2) permitted NSAIDs is above the primary thresholds:

1. For a first offense:

a. A suspension or revocation of licensing privileges from zero days to sixty (60) days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked;

b. Payment of a fine of \$500 to \$1,000; and

c. Forfeiture of purse money won.

2. For a second offense within a 365-day period:

a. A suspension or revocation of licensing privileges from sixty (60) days to 180 days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked;

b. Payment of a fine of \$1,000 to \$2,500; and

c. Forfeiture of purse money won.

3. For a third offense within a 365-day period:

a. A suspension or revocation of licensing privileges from 180 days to one (1) year. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked;

b. Payment of a fine of \$2,500 to \$5,000; and

c. Forfeiture of purse money won.

(b) For violations where the concentration of one (1) of the two (2) permitted NSAIDs is above the primary threshold and one (1) of the two (2) permitted NSAIDs is above the secondary threshold:

1. For a first offense:

a. A suspension or revocation of licensing privileges from zero days to fifteen (15) days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked;

b. Payment of a fine of \$250 to \$750; and

c. Forfeiture of purse money won.

2. For a second offense within a 365-day period:

a. A suspension or revocation of licensing privileges from fifteen (15) days to thirty (30) days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked;

b. Payment of a fine of \$750 to \$1,500; and

c. Forfeiture of purse money won.

3. For a third offense within a 365-day period:

a. A suspension or revocation of licensing privileges from thirty (30) days to sixty (60) days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked;

b. Payment of a fine of \$1,500 to \$3,000; and

c. Forfeiture of purse money won.

(c) For violations where the concentrations of both of the two (2) permitted NSAIDs are below the primary threshold and both of the two (2) permitted NSAIDs are above the secondary threshold:

1. For a first offense[within a 365-day period]:

a. A suspension or revocation of licensing privileges from zero to five (5) days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked; and

b. Payment of a fine of \$250 to \$500.

2. For a second offense within a 365-day period:

a. A suspension or revocation of licensing privileges from five (5) days to ten (10) days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked; and

b. Payment of a fine of \$500 to \$1,000.

3. For a third offense within a 365-day period:

a. A suspension or revocation of licensing privileges from ten (10) days to fifteen (15) days. Section 9 of this administrative regulation shall apply to a person whose licensing privileges have been suspended or revoked; and

b. Payment of a fine of \$1,000 to \$2,500.

(6)[(5)] Class D drug.

(a) The penalty for a violation involving a Class D drug shall be a written warning to the trainer and owner.

(b) Multiple violations involving a Class D drug may result in the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

1. A suspension of licensing privileges from zero days to five (5) days; and

2. Payment of a fine of not more than \$250.

Section 6. Out-of-Competition Testing. The penalties established in 811 KAR 1:240, Section 8, shall apply to violations involving the prohibited substances and practices described in Section 2 of that administrative regulation.

Section 7. TCO2 penalties. A person who violates or causes the violation of 811 KAR 1:090, Section 20(6), (7), or (8), shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

(1) For a first offense involving a positive pre-race test result, the licensee shall be issued a warning.

(2) For a first offense involving a positive post-race test result:

(a) A suspension or revocation of licensing privileges from zero days to ninety (90) days. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked; and

(b) Payment of a fine of \$1,000 to \$1,500.

(3) For a second offense involving a positive pre-race or post-race test result:

(a) A suspension or revocation of licensing privileges from three (3) months to six (6) months. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked;

(b) Payment of a fine of \$1,500 to \$3,000; and

(c) Forfeiture of purse money won.

(4) For a third offense involving a positive pre-race or post-race test result:

(a) A suspension or revocation of licensing privileges from six (6) months to one (1) year. Section 9 of this administrative regulation shall apply to any person whose licensing privileges have been suspended or revoked;

(b) Payment of a fine of \$3,000 to \$5,000; and

(c) Forfeiture of purse money won.

(5) Subsequent offenses:

(a) A suspension or revocation of licensing privileges from one (1) year up to a lifetime license revocation; and

(b) Forfeiture of purse money won.

(6) Horse ineligible. A horse that registers a TCO2 level in violation of 811 KAR 1:090 shall be ineligible to race in Kentucky as follows:

- (a) For a first offense, no period of ineligibility;
 - (b) For a second offense, the horse shall be ineligible from fifteen (15) days to sixty (60) days;
 - (c) For a third offense, the horse shall be ineligible from sixty (60) days to 180 days; and
 - (d) For a fourth offense, the horse shall be ineligible from 180 days to one (1) year.
- (7) In any instance of a positive pre-race TCO2 test result, the horse shall be scratched.

Section 8. Shock Wave Machine and Blood Gas Machine Penalties. A person who violates or causes a violation of 811 KAR 1:090, Section 20(5), (9), or (10), regarding a shock wave machine or blood gas machine shall be subject to the following penalties as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:

- (1) For a first offense:
 - (a) A suspension or revocation of licensing privileges from thirty (30) days to ninety (90) days;
 - (b) Payment of a fine of \$1,000 to \$5,000; and
 - (c) Forfeiture of purse money won.
- (2) For a second offense:
 - (a) A suspension or revocation of licensing privileges from ninety (90) days to 180 days;
 - (b) Payment of a fine of \$5,000 to \$10,000; and
 - (c) Forfeiture of purse money won.
- (3) For a third offense:
 - (a) A suspension or revocation of licensing privileges from 180 days to one (1) year;
 - (b) Payment of a fine of \$10,000 to \$20,000; and
 - (c) Forfeiture of purse money won.

Section 9. Persons with a Suspended or Revoked License. (1) A person shall not train a horse or practice veterinary medicine for the benefit, credit, reputation, or satisfaction of an inactive person. The partners in a veterinary practice may provide services to horses if the inactive person does not receive a pecuniary benefit from those services.

- (2) An associated person of an inactive person shall not:
 - (a) Assume the inactive person's responsibilities at a location under the jurisdiction of the commission;
 - (b) Complete an entry form for a race to be held in Kentucky on behalf of or for the inactive person or an owner or customer for whom the inactive person has worked; or
 - (c) Pay or advance an entry fee for a race to be held in Kentucky on behalf of or for the inactive person or an owner or customer for whom the inactive person has worked.
- (3) An associated person who assumes the responsibility for the care, custody, or control of an unsuspended horse owned (fully or partially), leased, or trained by an inactive person shall not:
 - (a) Be paid a salary directly or indirectly by or on behalf of the inactive person;
 - (b) Receive a bonus or any other form of compensation in cash, property, or other remuneration or consideration;
 - (c) Make a payment or give remuneration or other compensation or consideration to the inactive person or associated person; or
 - (d) Train or perform veterinary work for the inactive person or an owner or customer of the inactive person at a location under the jurisdiction of the commission.
- (4) A person who is responsible for the care, training or veterinary services provided to a horse formerly under the care, training or veterinary services of an inactive person shall:
 - (a) Bill customers directly on his or her bill form for any services rendered at or in connection with any race meeting in Kentucky;
 - (b) Maintain a personal checking account totally separate from and independent of that of the inactive person to be used to pay expenses of and deposit income from an owner or client of the inactive person;
 - (c) Not use the services, directly or indirectly, of current employees of the inactive person; and
 - (d) Pay bills related to the care, training and racing of the horse

from a separate and independent checking account. Copies of the invoices for the expenses shall be retained for not less than six (6) months after the date of the reinstatement of the license of the inactive person or the expiration of the suspension of the inactive person's license.

Section 10. Other Disciplinary Measures. (1) A person who violates 811 KAR 1:090, Section 6, regarding furosemide on race day shall be treated the same as a person who has committed a Class C drug violation.

(2) A person who violates 811 KAR 1:090, Section 8(6), for administering a non-steroidal anti-inflammatory drug other than phenylbutazone or flunixin shall be treated the same as a person who has committed a Class C drug violation.

(3) A person who violates 811 KAR 1:090, Section 20(2), shall be treated the same as a person who has committed a drug violation of the same class, as determined by the commission after consultation with the Equine Drug Research Council.

(4) A person who violates 811 KAR 1:090, Section 20(3), shall be treated the same as a person who has committed a Class A drug violation.

(5) An association in violation of Section 2(19), (20), (21), or (22) of this administrative regulation shall, together with its officers, be subject to a suspension or revocation of licensing privileges for up to thirty (30) days and payment of a fine up to \$5,000 in keeping with the seriousness of the violation and the facts of the case.

Section 11. Disciplinary Measures by Judges. Upon finding a violation or an attempted violation of 811 KAR Chapter 1 or KRS Chapter 230, if not otherwise provided for in this administrative regulation, the judges may impose one (1) or more of the following penalties:

- (1) If the violation or attempted violation may affect the health or safety of a horse or race participant, or may affect the outcome of a race, declare a horse or a licensee ineligible to race or disqualify a horse or a licensee in a race;
- (2) Suspend or revoke a person's licensing privileges for a period of time of not more than five (5) years in proportion to the seriousness of the violation and the facts of the case;
- (3) Cause a person, licensed or unlicensed, found to have interfered with, or contributed toward the interference of the orderly conduct of a race or race meeting, or person whose presence is found by the judges to be inconsistent with maintaining the honesty and integrity of the sport of horse racing, to be excluded or ejected from association grounds or from a portion of association grounds; and
- (4) Payment of a fine in an amount not to exceed \$50,000 as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case.

Section 12. Disciplinary Measures by the Commission. (1) Upon finding a violation or an attempted violation of 811 KAR Chapter 1 or KRS Chapter 230, if not otherwise provided for in this administrative regulation, the commission may impose one (1) or more of the following penalties:

- (a) If the violation or attempted violation may affect the health or safety of a horse or race participant, or may affect the outcome of a race, declare a horse or a licensed person ineligible to race or disqualify a horse or a licensed person in a race;
 - (b) Suspend or revoke a person's licensing privileges for a period of time of not more than five (5) years in proportion to the seriousness of the violation;
 - (c) Cause a person found to have interfered with or contributed toward the interference of the orderly conduct of a race or race meeting, or person whose presence is found by the commission to be inconsistent with maintaining the honesty and integrity of horse racing, to be excluded or ejected from association grounds or a portion of association grounds; and
 - (d) Payment of a fine of up to \$50,000 as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case.
- (2) Upon appeal of a matter determined by the judges the commission may:

(a) Order a hearing de novo of a matter determined by the judges; and

(b) Reverse or revise the judges' ruling in whole or in part, except as to findings of fact by the judges' ruling regarding matters that occurred during or incident to the running of a race and as to the extent of disqualification fixed by the judges for a foul in a race.

ROBERT M. BECK, Jr., Chairman
ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: December 30, 2013

FILED WITH LRC: January 10, 2014 at 2 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014 at 10:00 AM, at the offices of the Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511. Individuals interested in being heard at this hearing shall notify the Kentucky Horse Racing Commission in writing by February 18, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be 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 February 28, 2014. Please send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

CONTACT PERSON: Susan B. Speckert, General Counsel, Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511, phone (859) 246-2040, fax (859) 246-2039.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Susan B. Speckert

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes penalties for violations of 811 KAR 1:090 and other administrative regulations and statutes thereby giving licensees and other participants notice of consequences of violations.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to fulfill the statutory mandates found in KRS 230.215(2) and KRS 230.240(2). KRS 230.215(2) states that, [I]t is hereby declared the purpose and intent of this chapter in the interest of the public health, safety, and welfare, to vest in the racing commission forceful control of horse racing in the Commonwealth with plenary power to promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth... KRS 230.240(2) states that, The racing commission shall promulgate administrative regulations for effectively preventing the use of improper devices, and restricting or prohibiting the use and administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. Without this administrative regulation, the commission would be unable to fulfill the statutory mandates set forth above.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 230.215(2) mandates that the commission establish the conditions under which horse racing and pari-mutuel wagering thereon shall be conducted in Kentucky and charges it to, "promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth." KRS 230.240(2) further requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation enables the commission to fulfill its statutory mandates by providing a means to enforce its rules and regulations. Along with 811 KAR 1:090, this

administrative regulation allows the commission to "maintain horse racing at horse race meetings in the Commonwealth of the highest quality and free of any corrupt, incompetent, dishonest, or unprincipled horse racing practices, and to regulate and maintain horse racing at race meetings in the Commonwealth so as to dissipate any cloud of association with the undesirable and maintain the appearance as well as the fact of complete honesty and integrity of horse racing in the Commonwealth." See KRS 230.215.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: KRS 230.215 articulates the commission's statutory mandate to regulate horse racing in Kentucky "free of any corrupt, incompetent, dishonest, or unprincipled horse racing practices, and to regulate and maintain horse racing at race meetings in the Commonwealth so as to dissipate any cloud of association with the undesirable and maintain the appearance as well as the fact of complete honesty and integrity of horse racing in the Commonwealth." KRS 230.240 requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation enables the commission to fulfill its statutory mandates by providing a means to enforce its rules and regulations.

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

(a) How the amendment will change this existing administrative regulation: The amendments to this administrative regulation provide the penalties for certain amendments to the standardbred medication administrative regulation, 811 KAR 1:090. Like the changes to the medication administrative regulation, the changes to this administrative regulation are consistent with how the applicable substances are treated for Thoroughbred and quarter horse, appaloosa, and Arabian.

(b) The necessity of the amendment to this administrative regulation: Changes to this administrative regulation are necessitated by changes to the medication administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 230.215(2) grants the commission the authority to regulate conditions under which horse racing and pari-mutuel wagering thereon shall be conducted in Kentucky and charges it to, "promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth." KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation enables the commission to fulfill its statutory mandates by providing a means to enforce its rules and regulations.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation enables the commission to fulfill its statutory mandates by providing a means to enforce its rules and regulations.

(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 many licensees, including owners, trainers and veterinarians. It will also affect the commission.

(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 amendments to this administrative regulation will not require any particular action on the part of regulated entities. It provides notice to those entities of the potential penalties associated with a rule or administrative regulation violation.

(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 costs associated with this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The amendments establish a fair penalty structure based on medical science and make the standardbred penalties consistent with the other racing breeds. This administrative regulation provides notice to participants of the potential penalties associated with a rule or administrative regulation violation.

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

(a) Initially: None.

(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: N/A

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

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: The administrative regulation does not establish any fees or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied. All aspects of the administrative regulation will be applied equally to the affected parties.

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 Horse Racing Commission.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. Kentucky Revised Statutes 230.215, 230.225, 230.260, 230.290, 230.310, 230.320.

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? The amendment will not result in any additional costs to the commission.

(d) How much will it cost to administer this program for subsequent years? The amendment will not result in any additional costs to the commission.

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:

PUBLIC PROTECTION CABINET Kentucky Horse Racing Commission (Amendment)

811 KAR 2:093. Drug, medication, and substance classification schedule and withdrawal guidelines.

RELATES TO: KRS 230.210, 230.215, 230.240, 230.260, 230.265, 230.290, 230.320

STATUTORY AUTHORITY: KRS 230.215, 230.240, 230.260, 230.320

NECESSITY, FUNCTION, AND CONFORMITY: KRS 230.215(2) authorizes the Kentucky Horse Racing Commission to promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in Kentucky. KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. This administrative regulation establishes the drug classification schedule in effect in Kentucky and the withdrawal guidelines for permitted drugs, medications, and substances that may be administered to race horses competing in Kentucky.

Section 1. The Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule, KHRC 40-01, shall establish the respective classifications of all substances contained therein. The Kentucky Horse Racing Commission Withdrawal Guidelines Thoroughbred, Quarter Horse, Appaloosa, and Arabian, KHRC 40-02, shall provide certain mandatory treatment requirements and guidance and advice on withdrawal intervals as contained therein.

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Kentucky Horse Racing Commission Uniform Drug, Medication, and Substance Classification Schedule", KHRC 40-01, December 2013[April 2012]; and

(b) "Kentucky Horse Racing Commission Withdrawal Guidelines Thoroughbred, Quarter Horse, Appaloosa, and Arabian", KHRC 40-02, December 2013[April 2012].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Horse Racing Commission, 4063 Iron Works[Ironworks] Parkway, Building B, Lexington, Kentucky 40511, Monday through Friday, 8:00 a.m. to 4:30 p.m., or on the commission's[commission] Web site at <http://khrc.ky.gov>.

ROBERT M. BECK, Jr., Chairman

ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: December 30, 2013

FILED WITH LRC: January 10, 2014 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 25, 2014 at 10:00 a.m., at the offices of the Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Lexington, Kentucky 40511. Individuals interested in being heard at this hearing shall notify the Kentucky Horse Racing Commission in writing by February 18, 2014, five (5) working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be 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 February 28, 2014. Please send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

CONTACT PERSON: Susan B. Speckert, General Counsel, Kentucky Horse Racing Commission, 4063 Iron Works Parkway, Building B, Lexington, Kentucky 40511, phone (859) 246-2040, fax (859) 246-2039.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Susan B. Speckert

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation incorporates the Kentucky Horse Racing

Commission Uniform Drug, Medication, and Substance Classification Schedule (the "Schedule") and the Kentucky Horse Racing Commission Withdrawal Guidelines Thoroughbred, Quarter Horse, Appaloosa, and Arabian (the "Withdrawal Guidelines") by reference. Both documents are affected by scientific research and, thus, should be amended and updated on an ongoing basis based on developments in medical science. The Schedule establishes a classification system of regulated substances, and those classifications are then used to determine the appropriate penalty if there is a violation of 811 KAR 2:096 or 811 KAR 2:150. Thus, the Schedule provides notice to licensees regarding the potential penalty for use of a certain substance. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances. This amendment adds one substance to the list of Class A drugs contained in the Schedule. The amendment also makes certain changes to the Withdrawal Guidelines based on recommendations from the Racing Medication and Testing Consortium ("RMTC"). The RMTC is a national organization dedicated to the development, promotion, and coordination of policies, research, and educational programs that seek to ensure the fairness and integrity of horse racing and the health and welfare of racehorses and its participants at the national level. The RMTC developed regulatory thresholds and withdrawal guidance for 24 therapeutic medications having legitimate and conventional use in the care of racehorses of all breeds. The thresholds and withdrawal times are the result of a rigorous scientific process involving medication administrations to horses, serial sample collections, and statistical analysis of the resultant data. The Withdrawal Guidelines are conservative and intended to produce a substantial margin of safety so that ethical veterinary care can be provided to racehorses without fear of violating Kentucky's medication regulations. These thresholds and withdrawal guidelines have been adopted, or are under consideration, in multiple other racing jurisdictions. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing. Industry stakeholders have long maintained that uniformity is both desirable and necessary for fair competition.

(b) The necessity of this administrative regulation: The Schedule puts licensees on notice of how various regulated substances are classified. The classifications, in turn, dictate the penalties that will be levied if the substance in question is administered in violation of 811 KAR 2:096 or 811 KAR 2:150. The Withdrawal Guidelines are necessary to provide guidance to licensees regarding the regulated administration of certain medications and other substances prior to a horse competing in a race in Kentucky. The amendments are based on developments in medical science and represent a major step towards national uniformity in medication regulation and drug testing.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 230.215(2) mandates that the commission establish the conditions under which horse racing and pari-mutuel wagering thereon shall be conducted in Kentucky and charges it to, "promulgate administrative regulations prescribing conditions under which all legitimate horse racing and wagering thereon is conducted in the Commonwealth." KRS 230.240(2) further requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race. The Schedule classifies regulated substances to give notice to licensees and to allow the commission to levy the appropriate penalty in the event of a violation. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The Schedule classifies regulated substances, thereby providing notice to licensees and allowing the commission to levy the appropriate penalty in the event of a violation of 811 KAR 2:096 or 811 KAR 2:150. The Withdrawal Guidelines provide licensees with recommendations on the withdrawal intervals of certain regulated substances.

(2) If this is an amendment to an existing administrative

regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This amendment adds one substance to the list of Class A drugs contained in the Schedule. The amendment also makes certain changes to the Withdrawal Guidelines based on recommendations from the RMTC. The RMTC developed regulatory thresholds and withdrawal guidance for 24 therapeutic medications having legitimate and conventional use in the care of racehorses of all breeds. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing.

(b) The necessity of the amendment to this administrative regulation: The amendments are based on current scientific research and represent a major step towards national uniformity in medication regulation and drug testing.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 230.240(2) requires the commission to promulgate administrative regulations restricting or prohibiting the administration of drugs or stimulants or other improper acts to horses prior to the horse participating in a race.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to the Schedule will insure that the commission regulates the use of medication and other substances in racehorses in a manner that is consistent with the latest developments in medical science. The Withdrawal Guidelines provide guidance to licensees on administration of certain regulated substances.

(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 licensed owners, trainers and veterinarians. It will also affect the commission as it regulates the use of medication and other substances on horses competing 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: Licensees should take notice of the classifications provided in the Schedule and should follow the recommendations given in the Withdrawal Guidelines. The commission will use the Schedule to determine the appropriate penalties for violations of 811 KAR 2:096 and 811 KAR 2:150 and take into consideration compliance with the Withdrawal Guidelines when imposing a penalty.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Compliance with this administrative regulation will not result in any additional costs to any of the entities identified in question (3).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Licensees and the commission will benefit from the updates included in the Schedule and Withdrawal Guidelines because the updates reflect developments in medical science. In addition, these thresholds and withdrawal guidelines have been adopted, or are under consideration, in multiple other racing jurisdictions. The adoption of these thresholds and withdrawal guidelines represents a major step towards national uniformity in medication regulation and drug testing. Industry stakeholders have long maintained that uniformity is both desirable and necessary for fair competition.

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

(a) Initially: There are no anticipated costs to the commission.

(b) On a continuing basis: There are no anticipated costs to the commission.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: There is no additional funding necessary to implement or enforce the amendments to 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 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 or directly or indirectly increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applied. All aspects of this administrative regulation will be applied equally to the affected parties.

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 Horse Racing Commission.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 230.210, 230.215, 230.240, 230.260, 230.265, 230.290, 230.320.

(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 will have no effect on expenditures or revenues.

(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 costs associated with the implementation of the amendments to this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? There will be no costs associated with the implementation of the amendments to this administrative regulation.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES

Office of Health Policy

(Amendment)

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

RELATES TO: KRS Chapter 13B, 216.2920-216.2929

STATUTORY AUTHORITY: KRS 216.2923(3), 216.2925

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

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

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

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

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

(5) "Hospital" is defined by KRS 216.2920(6).

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

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

(b) Hospice care.

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

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

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

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

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

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

Section 3. Data Collection for Hospitals. (1) Inpatient Hospitalization records. Hospitals shall document every hospitalization they provide on a Standard Billing Form and shall, from every record, copy and provide to the cabinet the data specified in Section 12[13] of this administrative regulation.

(2) Outpatient services records.

(a) Hospitals shall document on a Standard Billing Form the outpatient services they provide and shall from every record, copy and provide to the cabinet the data specified in Section 12[13] of this administrative regulation.

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

(3) Data collection on patients. Hospitals shall submit required data on every patient as provided in Section 12[13] of this administrative regulation, regardless of the patient's billing or payment status.

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

(a) Ambulatory facilities shall document on a Standard Billing Form the outpatient services they provide and shall, for every

record, copy and provide to the cabinet the data specified in Section 13[14] of this administrative regulation.

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

(2) Data collection on patients. Ambulatory facilities shall submit required data on every patient as provided in Section 13[14] of this administrative regulation, regardless of the patient's billing or payment status.

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

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

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

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

(2) Data submission responsibility.

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

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

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

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

(3) Transmission of records.

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

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

(c) All providers shall submit data by electronic transmission as specified by the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals and the Kentucky Data Coordinator's Manual for Ambulatory Facilities~~[records on computer-readable electronic media]~~.

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

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

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

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

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

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

(a) Contain data, which during that quarter became final as

specified in Section 5(1) of this administrative regulation; and

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

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

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

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

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

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

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

(b) Providers shall submit to the cabinet corrected data by electronic transmission~~[or postmarked mailing]~~ within thirty (30) days.

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

(3) Percentage error rate.

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

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

(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.~~[(d) For the first data submission, the cabinet shall not count as errors any data for patients admitted prior to thirty (30) days of the effective date of this administrative regulation.]~~

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

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

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

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

~~(c) Corrected data submitted to the cabinet shall be uniformly completed and formatted according to the cabinet's coding and transmission~~

~~specifications contained in the Kentucky Data Coordinator's Manual for Ambulatory Facilities.~~

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

~~(3) Percentage error rate.~~

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

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

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

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

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

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

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

~~Section 9[10]. Extension or Waiver of Data Submission Timelines. (1) Providers experiencing extenuating circumstances or hardships may request from the cabinet, in writing, a data submission extension or waiver.~~

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

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

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

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

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

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

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

~~Section 10[11]. Appeals for Providers. (1) A provider notified of its noncompliance and assessed a fine pursuant to Section 8[9](1) of this administrative regulation shall have the right to appeal within thirty (30) days of the date of the notification letter.~~

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

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

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

~~conduct the hearing in accordance with KRS Chapter 13B.~~

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

~~Section 11[12]. Working Contacts for Providers. (1) On or before the last day of the data reporting period[By January 1 of each calendar year], a provider shall report by electronic transmission[letter] to the cabinet the names and telephone numbers of a designated contact person and one (1) back-up person to facilitate technical follow-up in data reporting and submission.~~

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

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

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

~~Section 12[13]. Required Data Elements for Hospitals. (1) Hospitals shall ensure that each record submitted to the cabinet contains at least the data elements identified in this section and as provided on the Standard Billing Form.~~

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

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

Required	DATA ELEMENT LABEL
Yes	*Provider Assigned Patient Control Number
Yes	*Provider Assigned Medical Record Number
Yes	*Type of Bill (inpatient, outpatient or other)
Yes	*Federal Tax Number or Employer Identification Number (EIN)
Yes	*Facility-specific NPI
Yes	*Statement Covers Period
Yes	*Patient City and Zip Code
Yes	*Patient Birth date
Yes	*Patient Sex
Yes	*Admission/Start of Care Date
Yes	Admission Hour
Yes	*Type of Admission
Yes	*Source of Admission
Yes	*Patient Status (at end of service or discharge)
No	Occurrence Codes & Dates
No	Value Codes and Amounts, including birth weight in grams
Yes	*Revenue Codes/Groups
Yes	*HCPCS/Rates/Hipps Rate Codes
No	Units of Service
Yes	*Total Charges by Revenue Code Category
Yes	*Payor Identification - Payor Name
Yes	*National Provider Identifier
Yes	*Diagnosis Version Qualifier - ICD version 9.0 or 10.0
Yes	*Principal Diagnosis Code
No	Principal Diagnosis Code present on admission identifier for non-Medicare claims
Yes	*Principal Diagnosis Code present on admission identifier for Medicare claims
Yes	*Secondary and Other Diagnosis Codes if present
No	Secondary and Other Diagnosis code present on admission identifier if present for non-Medicare

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	claims
Yes	*Secondary and Other Diagnosis code present on admission identifier if present for Medicare claims
No	Inpatient Admitting Diagnosis or Outpatient reason for visit
Yes	*External Cause of Injury Code (E-code) if present
No	External Cause of Injury (E-code) present on admission identifier on non-Medicare claims if present
Yes	*External Cause of Injury (E-code) present on admission identifier on Medicare claims if present
Yes	*Principal Procedure Code & Date if present
Yes	*Secondary and Other Procedure Codes & Date if present
Yes	*Attending Physician NPI/QUAL/ID
No	Operating Clinician ID Number/NPI
No	Other Physician NPI/QUAL/ID
Yes	*Race
Yes	*Ethnicity
Yes	*Procedure Coding Method

Section 13[14]. Required Data Elements for Ambulatory Facilities.(1) Ambulatory facilities shall ensure that each record submitted to the cabinet contains at least the data elements identified in this section and as provided on the Standard Billing Form.

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

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

Required	DATA ELEMENT LABEL
Yes	*Patient Birth date
Yes	*Patient Sex
Yes	*Zip Code
Yes	*1st Individual Payer ID#
Yes	*Admission/Start of Care Date
Yes	*Type of Bill
Yes	*Principal Diagnosis Code
Yes	*Secondary and Other Diagnosis Codes if present
Yes	*Principal Procedure Code & Date
Yes	*Secondary and Other Procedure Codes & Date if present
Yes	*1st Units of Service
Yes	*1st Charge
No	Secondary and Other Units of Service and Charge
Yes	*Total Charges for the Case
Yes	*Attending Clinician NPI
Yes	*Provider Assigned Patient ID#
Yes	*1st Insurer Group #
No	2nd Insurer Group #
Yes	*Operating Clinician NPI
Yes	*Billing Facility-specific NPI
Yes	*Federal Tax Number or Employer Identification Number (EIN)
Yes	*Statement Covers Period
Yes	*Primary Payor Name
No	Secondary Payor Name
Yes	*Race
Yes	*Ethnicity
Yes	*HCPCS/Rates/Hipps Rate Codes

Section 14[15]. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals", revised January 1, 2014[2013]; and

(b) "Kentucky Data Coordinator's Manual for Ambulatory Facilities," revised January 1, 2014[2013].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, 275 East Main Street 4WE, Frankfort, Kentucky 40621[40604], Monday through Friday, 8 a.m. to 4:30 p.m.

EMILY WHELAN PARENTO, Executive Director
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 10, 2013

FILED WITH LRC: December 17, 2013 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014, at 9:00 a.m. in Auditorium A, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone 502-564-7905, fax 502-564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Diona Mullins, (502) 564-9592

1. Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation provides clarification and instruction to specified health care providers on the process necessary to submit copies of administrative claims data to the Cabinet.

(b) The necessity of this administrative regulation: This administrative regulation is necessary so that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data. The administrative regulation contains the updated data submission manuals for hospitals and ambulatory care facilities. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider –Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary to ensure that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data to enable the Cabinet to publish the data and reports as required by KRS 216.2925.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed instructions to specified health care providers relating to the data elements, forms and timetables necessary to comply with the statute.

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

(a)How this amendment will change this existing administrative regulation: This administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider –Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of

the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

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

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statute by providing a standardized method of reporting by hospitals and ambulatory care facilities.

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

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation will affect 229 hospitals and ambulatory facilities which submit data to the Cabinet.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will collect and submit data as required. Entities are already required to submit data. This administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider – Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Data integrity is improved as all applicable payor codes are now included in the manuals and instructions have been provided related to 1) the addition of the requirement to report new CPT/HCPCS codes, 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the five (5) separate monthly actual discharge counts for outpatient services.

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. The Office of Health Policy currently collects data and has the necessary data collection system in place.

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

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding for the implementation and enforcement of this administrative regulation will be the Office of Health Policy's existing budget. No new funding will be needed to implement the provisions of the amended 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 amendment may impact any government owned, controlled or proposed hospitals and ambulatory care facilities.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. The authorizing statutes are KRS 216.2920-216.2929.

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

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

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

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

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

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

Revenues (+/-): None

Expenditures (+/-): None

Other Explanation: None

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Commissioner's Office

(Amendment)

907 KAR 1:019. Outpatient Pharmacy Program.

RELATES TO: KRS Chapter 13B, 205.510, 205.560, 205.561, 205.5631-205.5639, 205.564, 205.6316, 205.8451, 205.8453, 217.015, 217.822, 42 C.F.R. 430.10, 431.54, 440.120, 447.331, 447.332, 447.333, 447.334, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396r-8

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.561, 205.5632, 205.5634, 205.5639(2), 205.564(10), (13)[, 2010 Extra Sess. Ky. Acts ch. 1, Part I.G.3.b.(26)]

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has the 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 for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.560 provides that the scope of medical care for which Medicaid shall pay is determined by

administrative regulations promulgated by the cabinet. This administrative regulation establishes the provisions for coverage of drugs through the Medicaid Outpatient Pharmacy Program.

Section 1. Definitions. (1) "Brand name drug" means the registered trade name of a drug which was originally marketed under an original new drug application approved by the Food and Drug Administration.

(2) "Commissioner" is defined by KRS 205.5631(1).

(3) "Covered drug" means a drug for which the Department for Medicaid Services provides reimbursement if medically necessary and if provided, but not otherwise excluded, in accordance with Sections 2 and 3 of this administrative regulation.

(4) "Covered outpatient drug" is defined by 42 U.S.C. 1396r-8(k)(2).

(5) "Department" means the Department for Medicaid Services or its designated agent.

(6) "Department's pharmacy Internet Web site" or "Web site" means the Internet Web site maintained by the Department for Medicaid Services and accessible at <http://www.chfs.ky.gov/dms/Pharmacy.htm>.

(7) "Dosage form" means the type of physical formulation used to deliver a drug to the intended site of action, including a tablet, an extended release tablet, a capsule, an elixir, a solution, a powder, a spray, a cream, an ointment, or any other distinct physical formulation recognized as a dosage form by the Food and Drug Administration.

(8) "Drug list" means the Department for Medicaid Services' list which:

(a) Specifies:

1. Drugs, drug categories, and related items not covered by the department; and

2. Covered drugs requiring prior authorization or having special prescribing or dispensing restrictions or excluded medical uses; and

(b) May include information about other drugs, drug categories, or related items and dispensing and prescribing information.

(9) "Drug Management Review Advisory Board" or "DMRAB" or "board" means the board established pursuant to KRS 205.5636.

(10) "Effective" or "effectiveness" means a finding that a pharmaceutical agent does or does not have a significant, clinically-meaningful therapeutic advantage in terms of safety, usefulness, or clinical outcome over the other pharmaceutical agents based on pertinent information from a variety of sources determined by the department to be relevant and reliable.

(11) "Emergency supply" means a seventy-two (72) hour supply.

(12) "Enrollee" means a recipient who is enrolled with a managed care organization.

(13) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(14)(13) "Food and Drug Administration" means the Food and Drug Administration of the United States Department of Health and Human Services.

(15)(14) "Generic drug" or "generic form of a brand name drug" means a drug which contains identical amounts of the same active drug ingredients in the same dosage form and which meets official compendia or other applicable standards of strength, quality, purity, and identity in comparison with the brand name drug.

(16)(15) "Legend drug" means a drug so defined by the Food and Drug Administration and required to bear the statement: "Caution: Federal law prohibits dispensing without prescription".

(17) "Managed care organization" 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.

(18)(16) "Manufacturer" is defined in 42 U.S.C. 1396r-8(k)(5).

(19)(17) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(20)(18) "Official compendia" or "compendia" is defined in 42 U.S.C. 1396r-8(g)(1)(B)(i).

(21)(19) "Over-the-counter drug" or "OTC drug" means a drug approved by the Food and Drug Administration to be sold without bearing the statement "Caution: Federal law prohibits dispensing without prescription".

(22)(20) "Pharmacy and Therapeutics Advisory Committee" or "committee" or "P&T Committee" means the pharmacy advisory committee established by KRS 205.564.

(23)(21) "Prescriber" means a health care professional who:

(a) within the scope of practice under Kentucky licensing laws, has the legal authority to write or order a prescription for the drug that is ordered;

(b) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672; and

(c) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671.

(24)(22) "Recipient" is defined by KRS 205.8451(9).

(25)(23) "Secretary" means the Secretary of the Cabinet for Health and Family Services.

(26)(24) "Supplemental rebate" means a cash rebate that offsets a Kentucky Medicaid expenditure and that supplements the Centers for Medicare and Medicaid Services National Rebate Program.

Section 2. Covered Benefits and Drug List. (1) A covered outpatient drug, nonoutpatient drug, or diabetic supply covered via this administrative regulation shall be:

(a) Medically necessary;

(b) Approved by the Food and Drug Administration; and

(c) Prescribed for an indication that has been approved by the Food and Drug Administration or for which there is documentation in official compendia or peer-reviewed medical literature supporting its medical use.

(2) A covered outpatient drug covered via this administrative regulation shall be prescribed on a tamper-resistant pad unless exempt pursuant to subsection (3) of this section.

(3) The tamper-resistant pad requirement established in subsection (2) of this section shall not apply to:

(a) An electronic prescription;

(b) A faxed prescription; or

(c) A prescription telephoned by a prescriber.

(4) To qualify as a tamper-resistant pad prescription, a prescription shall contain:

(a) One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and

(c) One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(5)(a) Except as provided in paragraph (b) of this subsection, the department shall cover the diabetic supplies listed in this paragraph via the department's pharmacy program and not via the department's durable medical equipment program established in 907 KAR 1:479:

1. A syringe with needle (sterile, 1cc or less);

2. Urine test or reagent strips or tablets;

3. Blood ketone test or reagent strip;

4. Blood glucose test or reagent strips for a home blood glucose monitor;

5. Normal, low, or high calibrator solution, chips;

6. Spring-powered device for lancet;

7. Lancets per box of 100; or

8. Home blood glucose monitor.

(b) The department shall cover the diabetic supplies listed in this paragraph via the department's durable medical equipment program established in 907 KAR 1:479 if:

1. The supply has an HCPCS code of A4210, A4250, A4252, A4253, A4256, A4258, A4259, E0607 or E2100;

2. The supply has an a HCPCS code of A4206 and a diagnosis of diabetes is present on the corresponding claim; or

3. Medicare is the primary payor for the supply.

(6) The department shall have a drug list which:

(a) Lists:

1. Drugs, drug categories, and related items not covered by the department and, if applicable, excluded medical uses for covered drugs; and

2. Maintenance drugs covered by the department;

(b) Specifies those covered drugs requiring prior authorization or having special prescribing or dispensing restrictions;

(c) Specifies those covered drugs for which the maximum quantity limit on dispensing may be exceeded;

(d) Lists covered over-the-counter drugs;

(e) Specifies those legend drugs which are permissible restrictions under 42 U.S.C. 1396r-8(d), but for which the department makes reimbursement;

(f) May include a preferred drug list of selected drugs which have a more favorable cost to the department and which prescribers are encouraged to prescribe, if medically appropriate;

(g) May be updated monthly or more frequently by the department; and

(h) Shall be posted on the department's Internet pharmacy Web site.

(6)(a) The department may implement drug treatment protocols requiring the use of medically-appropriate drugs which are available without prior authorization before the use of drugs which require prior authorization.

(b) The department may approve a request from the prescriber or a pharmacist for exemption of a specific recipient from the requirement established in paragraph (a) of this subsection, based on documentation that drugs available without prior authorization:

(a) Were used and were not an effective medical treatment or lost their effectiveness;

(b) Are reasonably expected to not be an effective medical treatment;

(c) Resulted in, or are reasonably expected to result in, a clinically-significant adverse reaction or drug interaction; or

(d) Are medically contraindicated.

Section 3. Exclusions and Limitations. (1) The following drugs shall be excluded from coverage:

(a) A drug which the Food and Drug Administration considers to be:

1. A less-than-effective drug; or

2. Identical, related, or similar to a less-than-effective drug;

(b) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:

1. A drug if used for anorexia, weight loss, or weight gain;

2. A drug if used to promote fertility;

3. A drug if used for cosmetic purposes or hair growth;

4. A drug if used for the symptomatic relief of cough and colds;

5. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;

6. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;

7. A barbiturate;

8. A benzodiazepine;

9. A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or

10. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;

(c) A drug for which the manufacturer has not entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a), unless there has been a review and determination by the department that it is in the best interest of a recipient for the department to make payment for the drug and federal financial participation is available for the drug;

(d) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service;

(e) A drug for which the department requires prior authorization

if prior authorization has not been approved; and

(f) A drug that has reached the manufacturer's termination date, indicating that the drug may no longer be dispensed by a pharmacy.

(2) If authorized by the prescriber, a prescription for a:

(a) Controlled substance in Schedule III-V may be refilled up to five (5) times within a six (6) month period from the date the prescription was written or ordered, at which time a new prescription shall be required; or

(b) Noncontrolled substance, except as prohibited in subsection (4) of this section, may be refilled up to eleven (11) times within a twelve (12) month period from the date the prescription was written or ordered, at which time a new prescription shall be required.

(3) For each initial filling or refill of a prescription, a pharmacist shall dispense the drug in the quantity prescribed not to exceed a thirty-two (32) day supply unless:

(a) The drug is designated in the department's drug list as a drug exempt from the thirty-two (32) day dispensing limit in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;

(b) A prior authorization request has been submitted on the Drug Prior Authorization Request Form (MAP-82001) and approved by the department because the recipient needs additional medication while traveling or for a valid medical reason, in which case the pharmacist may dispense the quantity prescribed not to exceed a three (3) month supply or 100 units, whichever is greater;

(c) The drug is prepackaged by the manufacturer and is intended to be dispensed as an intact unit and it is impractical for the pharmacist to dispense only a month's supply because one (1) or more units of the prepackaged drug will provide more than a thirty-two (32) day supply; or

(d) The prescription fill is for an outpatient service recipient, excluding an individual who is receiving supports for community living services in accordance with 907 KAR 1:145.

(4) A prescription fill for a maintenance drug for an outpatient service recipient who has demonstrated stability on the given maintenance drug, excluding an individual receiving supports for community living services in accordance with 907 KAR 1:145 or 907 KAR 12:010, shall be dispensed in a ninety-two (92) day supply unless:

(a) The department determines that it is in the best interest of the recipient to dispense a smaller supply; or

(b) The recipient is covered under the Medicare Part D benefit in which case the department shall not cover the prescription fill.

(5) The department may require prior authorization for a compounded drug that requires preparation by mixing two (2) or more individual drugs; however, the department may exempt a compounded drug or compounded drug category from prior authorization if there has been a review and determination by the department that it is in the best interest of a recipient for the department to make payment for the compounded drug or compounded drug category.

(6) A prescriber shall make his or her national provider identifier (NPI) available to a pharmacist, and the prescriber's NPI shall be recorded on each pharmacy claim.

~~(7)(a) Except as provided in paragraph (b), (c), or (d) of this subsection, the department shall cover no more than a total of four (4) prescriptions, of which no more than three (3) shall be brand name prescriptions per recipient per month.~~

~~(b) The four (4) prescription limit shall not apply if the recipient:~~

~~1. Is under nineteen (19) years of age;~~

~~2. Uses insulin for the management of diabetes; or~~

~~3. Is a nursing facility resident who does not have Medicare Part D drug coverage.~~

~~(c) A pharmacist may utilize a four (4) prescription limit override code for a recipient whose prescription will exceed the four (4) prescription limit if the prescription is prescribed:~~

~~1. For any of the following conditions:~~

~~a. Acute infection or infestation;~~

~~b. Bipolar disorder;~~

~~c. Cancer;~~

- d. Cardiac rhythm disorder;
- e. Chronic pain;
- f. ~~Coronary artery or cerebrovascular disease (advanced~~
~~arthrosclerotic disease);~~
- g. Cystic fibrosis;
- h. Dementia;
- i. Diabetes;
- j. End stage lung disease;
- k. End stage renal disease;
- l. Epilepsy;
- m. Hemophilia;
- n. HIV or AIDS or immunocompromised;
- o. Hyperlipidemia;
- p. Hypertension;
- q. Major depression;
- r. Metabolic syndrome;
- s. Organ transplant; or
- t. Psychotic disorder; or
- 2. As part of:
 - a. Acute therapy for migraine headache or acute pain; or
 - b. Suppressive therapy for thyroid cancer.

~~(d) An additional prescription or prescriptions shall be covered if the department determines that it is in the best interest of the recipient to cover an additional prescription or prescriptions whether brand name or generic.~~

~~(8) The department shall cover up to three (3) brand name prescriptions per member per month unless the department determines that it is in the best interest of the member to cover any additional brand name prescriptions.~~

~~(9) A refill of a prescription shall not be covered unless at least ninety (90) percent of the prescription, except for a refill for a recipient who is a resident of a personal care home or a resident of a facility reimbursed pursuant to 907 KAR 1:025 or 1:065, time period has elapsed.~~

~~(b) A refill of a prescription for a recipient who is a resident of a facility or entity referenced in paragraph (a) of this subsection shall not be covered unless at least eighty (80) percent of the prescription time has lapsed.~~

Section 4. Prior Authorization Process. (1)(a) To request prior authorization for a drug:

1. The applicable form as required by this section shall be completed and submitted to the department:

- a. By fax, mail, express delivery service, or messenger service; or
- b. Via the department's pharmacy Internet Web site; or

2. A requester may provide the information required on the applicable form to the department verbally via the telephone number published on the department's pharmacy Internet Web site.

(b) If drug therapy needs to be started on an urgent basis to avoid jeopardizing the health of a recipient or to avoid causing substantial pain and suffering, the completed request form may be sent to the department's urgent fax number or submitted to the department via the department's pharmacy Internet Web site.

(2) A Drug Prior Authorization Request Form shall be used by a:

- (a) Prescriber or pharmacist to request prior authorization for a drug except for a brand name drug, Suboxone®, Subutex®, Zyvox®, Synagis®, or an atypical antipsychotic agent;
- (b) Pharmacist to request an early refill of a prescription; or
- (c) Pharmacist to obtain prior authorization for special dispensing requests involving exceptions to the thirty-two (32) day maximum quantity limit including additional drugs needed for travel or other valid medical reasons.

(3)(a) Except as established in paragraph (c) of this subsection, a Brand Name Drug Request Form shall be used by a prescriber to request prior authorization for a brand name drug if a generic form of the drug is available.

(b) Regarding a Brand Name Drug Request Form, a prescriber shall:

- 1. Complete the form;

2. Include on the form:

- a. The handwritten phrase "brand medically necessary" or "brand necessary"; and
- b. The provider's signature for each specific drug requested; and

3. Indicate:

a. Whether the recipient has received treatment with available generic forms of the brand name drug and the length of therapy; and

b. Why the recipient's medical condition is unable to be adequately treated with the generic forms of the drug.

(c) Submission of a Brand Name Drug Request Form shall not be required if:

1. The department has specifically exempted the drug, via the drug list, from this requirement;

2. It has been determined by the department to be in the best interest of a recipient not to require submission of a Brand Name Drug Request Form; or

3. The prescriber certifies that the brand name drug is medically necessary in accordance with subsection (3)(b) of this section.

(d) In addition to the requirements established in paragraphs (a) through (c) of this subsection, the prescriber shall certify a brand name only request by including for each brand name drug requested, the prescriber's signature and the phrase "Brand Medically Necessary" or "Brand Necessary" handwritten directly on:

- 1. The prescription;
- 2. The nursing facility order sheet; or
- 3. A separate sheet of paper that:
 - a. Includes the name of the recipient and the brand name drug requested; and
 - b. Is attached to the original prescription or nursing facility order sheet.

(4) A Mental Health Drug Authorization Request Form for Atypical Antipsychotic Agents shall be:

- (a) Used to request prior authorization for an atypical antipsychotic drug; and
- (b) Completed and submitted as directed on the form.

(5) A Suboxone® and Subutex® Prior Authorization Request Form shall be:

- (a) Used to request prior authorization for Suboxone® or Subutex®; and
- (b) Completed and submitted as directed on the form.

(6) A Zyvox® (linezolid) Drug Authorization Request Form shall be:

- (a) Used to request prior authorization for Zyvox®; and
- (b) Completed and submitted as directed on the form.

(7) A Synagis® Prior Authorization Request Form shall be:

- (a) Used to request prior authorization for Synagis®; and
- (b) Completed and submitted as directed on the form.

(8) If a recipient presents a prescription to a pharmacist for a drug which requires prior authorization, the pharmacist:

(a) Shall, unless the form is one[~~(1)~~] which has to be completed by the prescriber, submit a request for prior authorization in accordance with this section;

(b) Shall notify the prescriber or the prescriber's authorized representative that the drug requires prior authorization and:

1. If the prescriber indicates that a drug list alternative available without prior authorization is acceptable and provides a new prescription, shall dispense the drug list alternative; or

2. If the prescriber indicates that drug list alternatives available without prior authorization have been tried and failed or are clinically inappropriate or if the prescriber is unwilling to consider drug list alternatives, shall:

a. Request that the prescriber obtain prior authorization from the department; or

b. Unless the form is one[~~(1)~~] which has to be completed by the prescriber, submit a prior authorization request in accordance with this section; or

(c) Except as restricted by subparagraphs 3 and 4 of this paragraph, may provide the recipient with an emergency supply of

the prescribed drug in an emergency situation in accordance with this subsection.

1. The emergency situation shall:

a. Occur outside normal business hours of the department's drug prior authorization office, except for medications dispensed to a long term care recipient in which an emergency supply may be dispensed after 5 p.m. EST; and

b. Exist if, based on the clinical judgment of the dispensing pharmacist, it would reasonably be expected that, by a delay in providing the drug to the recipient, the health of the recipient would be placed in serious jeopardy or the recipient would experience substantial pain and suffering.

2. At the time of the dispensing of the emergency supply, the pharmacist shall in accordance with this section:

a. Submit a prior authorization request to the department's urgent fax number or to the department via the department's pharmacy Internet Web site; or

b. If applicable, notify the prescriber as soon as possible that an emergency supply was dispensed and that the prescriber is required to obtain prior authorization for the requested drug from the department.

3. An emergency supply shall not be provided for an over-the-counter (OTC) drug.

4. An emergency supply shall not be provided for a drug excluded from coverage in accordance with Section 3(1) (a), (b) or (c) of this administrative regulation.

5. The quantity of the emergency supply shall be:

a. The lesser of a seventy-two (72) hour supply of the drug or the amount prescribed; or

b. The amount prescribed if it is not feasible for the pharmacist to dispense just a seventy-two (72) hour supply because the drug is packaged in such a way that it is not intended to be further divided at the time of dispensing but rather dispensed as originally packaged.

(9)(a) If a prescriber submits a prescription to a pharmacy via telephone, the prescriber shall also fax the prescription for a controlled substance to the pharmacy within forty-eight (48) hours of submitting it via telephone.

(b) A pharmacy shall not be denied payment for services for the failure of the prescriber to fax the prescription for a controlled substance to the pharmacy if the pharmacy:

1. Requests a faxed prescription from the prescriber;

2. Documents the request for a faxed prescription; and

3. Documents that a faxed prescription, which was not received, was not received.

(10) The department's notification of a decision on a request for prior authorization shall be made in accordance with the following:

(a) If the department approves a prior authorization request, notification of the approval shall be provided by telephone, fax or via the department's pharmacy Internet Web site to the party requesting the prior authorization and, if known, to the pharmacist.

(b) If the department denies a prior authorization request:

1. The department shall provide a denial notice:

a. By mail to the recipient and in accordance with 907 KAR 1:563; and

b. By fax, telephone, or if necessary by mail to the party who requested the prior authorization.

(11)(a) The department may grant approval of a prior authorization request for a drug for a specific recipient for a period of time not to exceed 365 days.

(b) Approval of a new prior authorization request shall be required for continuation of therapy subsequent to the expiration of a time-limited prior authorization request.

(12) Prior authorization of drugs for a Medicaid long-term care recipient in a nursing facility shall be in accordance with this subsection.

(a) The department may specify in its drug list specific drugs or drug classes which shall:

1. Not be exempted from prior authorization; or

2. Be exempt from prior authorization for Medicaid recipients in nursing facilities.

(b) A brand name drug for which the department requires

completion by the prescriber of a Brand Name Drug Request Form in accordance with this section shall not be exempted from prior authorization.

Section 5. Placement of Drugs on Prior Authorization. (1) Except as excluded by Section 3(1)(a) to (c) of this administrative regulation, upon initial coverage by the Kentucky Medicaid Program, a drug that is newly approved for marketing by the Food and Drug Administration under a product licensing application, new drug application, or a supplement to a new drug application and that is a new chemical or molecular entity shall be subject to prior authorization in accordance with KRS 205.5632.

(2) Upon request by the department, a drug manufacturer shall provide the department with the drug package insert information.

(3) The drug review process to determine if a drug shall require prior authorization shall be in accordance with this subsection and KRS 205.5632.

(a) The determination as to whether a drug is in an excludable category specified in Section 3(1) of this administrative regulation shall be made by the department.

1. If a drug, which has been determined to require prior authorization becomes available on the market in a new strength, package size, or other form that does not meet the definition of a new drug the new strength, package size, or other form shall require prior authorization.

2. A brand name drug for which there is a generic form that contains identical amounts of the same active drug ingredients in the same dosage form and that meets compendial or other applicable standards of strength, quality, purity, and identity in comparison with the brand name drug shall require prior authorization in accordance with Section 4 of this administrative regulation, unless there has been a review and determination by the department that it is in the best interest of a recipient for the department to cover the drug without prior authorization.

(b) The committee shall make a recommendation to the department regarding prior authorization of a drug based on:

1. A review of clinically-significant adverse side effects, drug interactions and contraindications and an assessment of the likelihood of significant abuse of the drug; and

2. An assessment of the cost of the drug compared to other drugs used for the same therapeutic indication and whether the drug offers a substantial clinically-meaningful advantage in terms of safety, effectiveness, or clinical outcome over other available drugs used for the same therapeutic indication. Cost shall be based on the net cost of the drug after federal rebate and supplemental rebates have been subtracted from the cost.

(c)1. Within thirty (30) days of the date the committee's recommendation is posted on the department's pharmacy Internet Web site, the secretary, in consultation with the commissioner and the department's pharmacy staff, shall review the recommendations of the committee and make the final determination whether a drug requires prior authorization.

2. If the recommendation of the committee is not accepted, the secretary shall inform the committee of the basis for the final determination in accordance with Section 8(3) of this administrative regulation.

(4) The department may exclude from coverage or require prior authorization for a drug which is a permissible restriction in accordance with 42 U.S.C. 1396r-8(d).

Section 6. Drug Management Review Advisory Board Meeting Procedures and Appeals. (1) A person may address the DMRAB if:

(a) The presentation is directly related to an agenda item; and

(b) The person gives notice to the department (and gives a copy to the DMRAB chairperson) by fax or email at least five (5) business days prior to the meeting.

(2) A verbal presentation:

(a) In aggregate per drug per drug manufacturer shall not exceed three (3) minutes with two (2) additional minutes allowed for questions from the DMRAB, if required; or

(b) By an individual on a subject shall not exceed three (3) minutes with two (2) additional minutes allowed for questions from the DMRAB, if required.

(3) The proposed agenda shall be posted on the department's pharmacy Internet Web site at least fourteen (14) days prior to the meeting.

(4) An appeal of a final decision by the commissioner by a manufacturer of a product shall be in accordance with KRS 205.5639(5). The appeal request shall:

- (a) Be in writing;
- (b) State the specific reasons the manufacturer believes the final decision to be incorrect;
- (c) Provide any supporting documentation; and
- (d) Be received by the department within thirty (30) days of the manufacturer's actual notice of the final decision.

Section 7. Pharmacy and Therapeutics Advisory Committee Meeting Procedures. (1) A P&T Committee meeting agenda shall be posted as required by KRS 205.564(6).

(2) A P&T committee meeting shall be conducted in accordance with KRS 205.564.

(3) A public presentation at a P&T Committee meeting shall comply with this subsection.

(a)1. A verbal presentation in aggregate per drug per drug manufacturer shall not exceed three (3) minutes with two (2) additional minutes allowed for questions from the P&T Committee, if required.

2. A verbal presentation by an individual on a subject shall not exceed five (5) minutes.

3. A request to make a verbal presentation shall be submitted in writing via fax or e-mail to the department with a copy to the chair of the P&T Committee no later than five (5) business days in advance of the P&T Committee meeting.

4. An individual may only present new information (package insert changes, new indication or peer-reviewed journal articles) on a product or information on a new product.

5. A presentation shall be limited to an agenda item.

(b) Nonverbal comments, documents, or electronic media material (limited to package insert changes, new indication, or peer reviewed journal articles) shall be:

1.a. E-mailed to the department in a Microsoft compatible format (for example, Word, Power Point, Excel or other standard file formats including Adobe Acrobat's pdf format); or

b. Mailed to the department with a total of twenty-five (25) copies mailed so that the department may distribute copies to P&T Committee members as well as to any other involved parties; and

2. Received by the department no later than seven (7) days prior to the P&T Committee meeting.

(4) The department may prepare written recommendations or options for drug review for the committee and shall post them as required by KRS 205.564(6).

(5) A recommendation by the committee shall require a majority vote.

(6) Recommendations of the committee shall be posted as required by KRS 205.564(8).

(7) A drug manufacturer may request that its name be placed on the department's distribution list for agendas of committee meetings. Placement of a drug manufacturer's name on the distribution list shall be valid through December 31 of each year, at which time the drug manufacturer shall be required to again request placement on the distribution list. To request placement of the drug manufacturer's name on the distribution list, the drug manufacturer shall submit the request in writing to the department and shall provide the following information about the drug manufacturer:

- (a) Manufacturer's name;
- (b) Mailing address;
- (c) Telephone number;
- (d) Fax number;
- (e) E-mail address; and
- (f) Name of a contact person.

Section 8. Review and Final Determination by the Secretary.

(1) An interested party who is adversely affected by a recommendation of the committee may submit a written exception to the secretary in accordance with the following:

(a) The written exception shall be received by the secretary within seven (7) calendar days of the date of the committee meeting at which the recommendation was made; and

(b) Only information that was not available to be presented at the time of the committee's meeting shall be included in the written exception.

(2) After the time for filing written exceptions has expired, the secretary shall consider the recommendation of the committee and all exceptions that were filed in a timely manner prior to making a final determination. The secretary shall issue a final determination, and a dated public notice of the final determination shall be posted on the department's pharmacy Internet Web site for six (6) months. A copy of the final determination may be requested from the department after it is issued.

(3) The secretary shall make a final determination in accordance with KRS 205.564(9).

(4) A final determination by the secretary may be appealed in accordance with KRS Chapter 13B. A decision of the secretary to remand the recommendation to the committee shall not constitute a final decision for purposes of an appeal pursuant to KRS Chapter 13B. An appeal request shall:

- (a) Be in writing;
- (b) Be sent by mail, messenger, carrier service, or express-delivery service to the secretary in a manner that safeguards the information;
- (c) State the specific reasons the final determination of the secretary is alleged to be erroneous or not based on the facts and law available to the committee and the secretary at the time of the decision;

(d) Be received by the secretary within thirty (30) days of the date of the posting of the final determination on the department's pharmacy Internet Web site; and

(e) Be forwarded by the secretary to the Administrative Hearings Branch of the Cabinet for Health and Family Services for processing in accordance with the provisions of KRS Chapter 13B.

Section 9. Confirming Receipt of Prescription. (1) A recipient, or a designee of the recipient, shall sign their name in a format which allows their signature to be reproduced or preserved at a pharmacy confirming that the recipient received the prescription.

(2) A pharmacist shall maintain, or be able to produce a copy of, a log of recipient signatures referenced in subsection (1) of this section for at least six (6) years.

Section 10. Exemptions to Prescriber Requirements. The department shall reimburse for:

(1) A full prescription prescribed by a provider who is not enrolled in the Kentucky Medicaid Program, if the department determines that reimbursing for a full prescription is in the best interest of the recipient; or

(2) An emergency supply of a prescription prescribed by a provider who is not enrolled in the Kentucky Medicaid Program, if the department determines that reimbursing for the emergency supply is in the best interest of the recipient.

Section 11. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient receives a dispensing of a drug prescription from a pharmacist enrolled with the Medicaid Program, the department shall not reimburse for the same drug prescription dispensing provided to the same recipient during the same time period from another pharmacist.

Section 12. Medicaid Program Participation Compliance. (1) A provider shall comply with:

- (a) 907 KAR 1:671;
- (b) 907 KAR 1:672; and
- (c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

Section 13. 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 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, or 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 14. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 15. Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage[A provision 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 provision; or

(2) Disapproves the provision].

Section 16.[42.] Appeal Rights. (1) An appeal of an adverse action taken by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be[A Medicaid recipient may appeal the department's denial, suspension, reduction, or termination of a covered drug or decision regarding the amount of a drug dispensed based upon an application of this administrative regulation] in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

Section 17.[43.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Drug Prior Authorization Request Form", May 15, 2007 edition;

(b) "Brand Name Drug Request Form", May 15, 2007 edition;

(c) "Mental Health Drug Authorization Request Form for Atypical Antipsychotic Agents", May 15, 2007 edition;

(d) "Subaxone® and Subutex® Prior Authorization Request Form", September 22, 2009 edition;

(e) "Zyvox® (linezolid) Drug Authorization Request Form", January 11, 2010 edition; and

(f) "Synagis® Prior Authorization Request Form", November 2010 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: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(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 provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation currently assists and will continue to assist in the effective administration of the authorizing statutes by establishing the provisions for coverage of drugs through Medicaid's outpatient pharmacy program.

(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 eliminates the four (4) prescriptions per recipient per month limit; inserts various program integrity requirements such as that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to a recipient at the same time by two (2) different providers; establishes third party liability requirements (Medicaid is the payor of last resort); establishes general provider participation requirements (program integrity requirements); establishes the option of using electronic signatures along with corresponding requirements; and establishes that DMS's coverage of drugs under this administrative regulation is contingent upon federal approval and federal funding.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to synchronize the Department for Medicaid Services' coverage of outpatient drugs with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid

"expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan imposed no prescription drug limit, DMS is removing the four (4) prescription per recipient per month limit. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing DMS's coverage of prescription drugs is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided.

(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 comporting with the Affordable Care Act, enhancing program integrity of Medicaid benefits, and protecting taxpayer revenues.

(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 comporting with the Affordable Care Act, enhancing program integrity of Medicaid benefits, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid-reimbursed prescribing providers are affected by this amendment and recipients are affected as well.

(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: Providers will need to continue to ensure that they bill appropriately.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Medicaid recipients will benefit by no longer being limited to four (4) prescriptions per month; however, the limit was not a hard limit.

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

(a) Initially: DMS anticipates little if any increased costs as a result of lifting the four (4) prescription per month limit as the limit was "soft" (could be over-riden if medically necessary.)

(b) On a continuing basis: DMS estimates DMS anticipates little if any increased costs as a result of lifting the four (4)

prescription per month limit as the limit was "soft" (could be over-riden if medically necessary.)

(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 to implement this amendment.

(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 was not appropriate in this administrative regulation as the administrative regulation applies equally to all those individuals or entities regulated by it.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b).

2. State compliance standards. KRS 205.560 establishes "The scope of medical care for which the Cabinet for Health and Family Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section."

3. Minimum or uniform standards contained in the federal mandate. This amendment is necessary to synchronize the Department for Medicaid Services' coverage of outpatient drugs with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan imposed no prescription drug limit, DMS is removing the four (4) prescription per recipient per month limit. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.)

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. It does not impose stricter standards or 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 is affected by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 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 amendment will not generate any additional revenue for state or local governments during the first year of implementation.

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

(c) How much will it cost to administer this program for the first year? No additional costs are necessary to implement this amendment during the first DMS anticipates little if any increased costs as a result of lifting the four (4) prescription per month limit as the limit was "soft" (could be over-ridden if medically necessary.)

(d) How much will it cost to administer this program for subsequent years? No additional costs are necessary to implement this amendment during subsequent years. DMS anticipates little if any increased costs as a result of lifting the four (4) prescription per month limit as the limit was "soft" (could be over-ridden if medically necessary.)

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 Community Alternatives
(Amendment)

907 KAR 1:030. Home health agency services.

RELATES TO: KRS 205.520, 42 C.F.R. 440.70, 447.325, 484.4, 45 C.F.R. 164.316, 42 U.S.C. 1396a-d
 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(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, 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 [for the provision of Medical Assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the coverage provisions and requirements relating to Medicaid Program home health care services [for which payment shall be made by the Medicaid Program in behalf of both the categorically needy and the medically needy].

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designee.

(2) "Electronic signature" is defined by KRS 369.102(8).

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Home health agency" or "HHA" means:

(a) An agency defined pursuant to 42 C.F.R. 440.70(d); and

(b) A Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.

(6) [(3)] "Home health aide" means a person who meets the home health aide requirements established in 902 KAR 20:081.

(7) [(4)] "Licensed practical nurse" or "LPN" means a person who is:

(a) Licensed in accordance with KRS 314.051; and

(b) Under the supervision of a registered nurse.

(8) "Managed care organization" 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.

(9) [(5)] "Medical social worker" means a person who meets the medical social worker requirements as established in 902 KAR 20:081.

(10) [(6)] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(11) [(7)] "Nursing service" means the delivery of medication, or treatment by a registered nurse or a licensed practical nurse supervised by a registered nurse, consistent with KRS Chapter 314 scope of practice provisions and the Kentucky Board of Nursing scope of practice determination guidelines.

(12) [(9)] "Occupational therapist" is defined by KRS 319A.010(3) [means a person who meets the occupational therapist requirements established in 902 KAR 20:081].

(13) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(14) [(9)] "Physical therapist" is defined by KRS 327.010(2) [means a person who meets the physical therapist requirements established in 902 KAR 20:081].

(15) "Physical therapy assistant" means a skilled health care worker who:

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

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

(16) [(10)] "Place of residence" means, excluding a hospital or nursing facility, the location at which a recipient resides.

(17) [(11)] "Plan of care" means a written plan which shall:

(a) Stipulate the type, nature, frequency and duration of a service; and

(b) Be reviewed and signed by a physician and HHA staff person at least every sixty (60) days.

(18) "Provider" is defined by KRS 205.8451(7).

(19) [(12)] "Qualified medical social worker" means a person who meets the qualified medical social worker requirements as established in 902 KAR 20:081.

(20) [(13)] "Qualified social work assistant" means a social work assistant as defined in 42 C.F.R. 484.4.

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

(22) [(14)] "Registered nurse" or "RN" is defined by KRS 314.011(5) [means a person licensed in accordance with KRS 314.041].

(23) [(15)] "Speech-language pathologist" is defined by KRS 334A.020(3) [means a person who meets the speech pathologist requirements established in 902 KAR 20:081].

(24) "Speech-language pathology assistant" is defined by KRS 334A.020(8).

Section 2. Conditions of Participation. (1) In order to provide home health services, a provider shall:

(a) Be an HHA; and

(b) Comply with:

1. 907 KAR 1:671;

2. [.] 907 KAR 1:672;

3. [and] 907 KAR 1:673;

4. All applicable state and federal laws; and

5. [(c) Comply with] The Home Health Services Manual.

(2) (a) A home health provider shall maintain a medical record for each recipient for whom services are provided.

(b) A [The] medical record shall:

1. Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service [(a) Substantiate the services billed to the

department and be signed and dated by HHA staff];

2. ~~[(b)]~~ Contain a copy of the plan of care;

3. ~~[(c)]~~ Document verbal orders from the physician, if applicable;

4. Except as established in paragraph (d) of this subsection, be retained for a minimum of five (5) years from the date a covered service is provided or until any audit dispute or issue is resolved beyond five (5) years;

5. ~~[(e)]~~, except in the case of a minor, whose records shall be retained for three (3) years after the recipient reaches the age of majority under state law, whichever is longest;

(e) Be kept in an organized central file within the HHA; and

6. ~~[(f)]~~ Be made available to the department upon request.

(c) The individual who provided a service shall date and sign the health record on the date that the individual provided the service.

(d) 1. If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (b)4. of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

2. In the case of a recipient who is a minor, the recipient's medical record shall be retained for three (3) years after the recipient reaches the age of majority under state law or the length established in paragraph (b)4 of this subsection or subparagraph 1 of this paragraph, whichever is longest.

(3) A provider shall comply with 45 C.F.R. Part 164.

(4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 3. Covered Services. (1) A home health service shall be:

(a) ~~[(Effective November 15, 2001, be)]~~ Prior authorized by the department to ensure that the service or modification of the service is medically necessary and adequate for the needs of the recipient;

(b) ~~[(Be)]~~ Provided pursuant to a plan of care; and

(c) ~~[(Be)]~~ Provided in a recipient's place of residence.

(2) The following services provided to a recipient by a home health provider~~[(,)]~~ who meets the requirements in Section 2 of this administrative regulation~~[(,)]~~ shall be covered by the department:

(a) A nursing service which shall:

1. Include part-time or intermittent nursing services;

2. If provided daily, be limited to thirty (30) days unless additional days are prior authorized by the department;

(b) A therapy service which shall:

1. Include physical therapy services provided by a physical therapist or a ~~qualified~~ physical therapy~~[therapist]~~ assistant ~~[as defined in 42 C.F.R. 484.4]~~ who is under the supervision of a ~~qualified~~ physical therapist;

2. Include occupational therapy services provided by an occupational therapist or an ~~a-qualified~~ occupational therapy assistant ~~[as defined in 42 C.F.R. 484.4]~~ who is under the supervision of an ~~a-qualified~~ occupational therapist;

3. Include speech language pathology services~~[therapy]~~ provided by ~~[or under the supervision of]~~ a speech-language pathologist or a speech-language pathology assistant who is under the supervision of a speech-language pathologist;

4. Be provided pursuant to a plan of treatment which shall be developed by the appropriate~~qualified~~ therapist and physician; and

5. Be provided in accordance with 907 KAR 1:023; and

6. Comply with the:

a. Physical therapy service~~[(, occupational therapy and speech therapy)]~~ requirements established in the:

(i) ["]Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is a physical therapy service provided to an adult; [February 2000 Edition"] or

(ii) ["]Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is a physical therapy service provided to a child; [April 2000 Edition"];

b. Occupational therapy requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is an occupational therapy service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is an occupational therapy service provided to a child; or

c. Speech language pathology service requirements established in the:

(i) Technical Criteria for Reviewing Ancillary Services for Adults if the service is a speech language pathology service provided to an adult; or

(ii) Technical Criteria for Reviewing Ancillary Services for Pediatrics if the service is a speech language pathology service provided to a child;

(c) A home health aide service which shall:

1. Include the performance of simple procedures as an extension of therapy services, personal care, range of motion exercises and ambulation, assistance with medications that are ordinarily self-administered, reporting a change in the recipient's condition and needs, incidental household services which are essential to the recipient's health care at home when provided in the course of a regular visit, and completing appropriate records;

2. Be provided by a home health aide who is supervised at least every fourteen (14) days~~[two (2) weeks]~~ by:

a. An RN;

b. A physical therapist, for any physical therapy services that are provided by the home health aide;

c. An occupational therapist, for any occupational therapy services that are provided by the home health aide; or

d. A speech-language pathologist~~[therapist]~~, for any speech language pathology~~[therapy]~~ services that are provided by the home health aide; and

3. Be a service that the recipient is either physically or mentally unable to perform;

(d) A medical social service which shall:

1. Be provided by a qualified medical social worker or qualified social work assistant; and

2. Be provided in conjunction with at least one (1) other service listed in this section;

(e) A disposable medical supply which shall:

1. Include the following:

a. An adapter;

b. An applicator;

c. Drainage supplies;

d. Dressing supplies;

e. Catheter, ileostomy or ureostomy supplies;

f. Colostomy supplies;

g. A detection reagent for other than sugar or ketone;

h. Except for the limitations contained in Section 4(5) of this administrative regulation, diapers, underpads or incontinent pants;

i. An egg crate mattress;

j. An enema or elimination supplies including a fleet enema or dulcolax suppository;

k. Gastrostomy supplies;

l. Gloves;

m. Inhalation therapy supplies;

n. Irrigation solutions;

o. IV therapy supplies;

p. Lambs wool or a synthetic pad;

q. A lotion, powder or cream for an invalid or bedfast recipient;

r. A nipple if designed for cleft palate;

s. Inexpensive occupational therapy supplies which may include a plastic utensil holder or a long arm reacher;

t. Suction supplies;

u. Support supplies which may include antiembolism stockings, support vest, support gauntlet, or support glove;

v. A syringe or needle (excluding an insulin syringe for a diabetic);

w. Tracheostomy supplies; or

x. Tubing; and

2. If provided to a recipient who is not in need of a home health visit, be required to maintain him in his place of residence. A physician shall certify the medical necessity of a disposable medical supply by completing and signing a MAP 248 form; and

(f) An enteral nutritional product which shall:

1. Be ingested orally or delivered by tube into the gastrointestinal tract; and

2. Provide for the total or supplemental nutrition of a recipient.

Section 4. Limitations and Exclusions from Coverage. (1) A domestic or housekeeping service which is unrelated to the health care of a recipient shall not be covered.

(2) A medical social service shall not be covered unless provided in conjunction with another service pursuant to Section 3 of this administrative regulation.

(3) Supplies for personal hygiene shall not be covered.[-]

(4) Drugs shall not be covered.

(5) Disposable diapers shall not be covered for a recipient age three (3) years and under, regardless of the recipient's medical condition.

(6) Except for the first week following a home delivery, a newborn or postpartum service without the presence of a medical complication shall not be covered.

(7) A recipient who has elected to receive hospice care shall not be eligible to receive coverage under the home health program.

(8)(a) There shall be an annual limit of twenty (20):

1. Occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection;

2. Physical therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection; and

3. Speech language pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limits established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for a speech language pathology service provided to the same recipient during the same time period via the home health services program.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 8. Auditing Authority. (1) The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights. (1) An appeal of an adverse[a negative] action taken by the department regarding a service and a recipient who is not enrolled with a managed care organization[Medicaid beneficiary] shall be in accordance with 907 KAR 1:563; or[-]

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671].

Section 11.[6.] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP-248, Commonwealth of Kentucky, Cabinet for Health Services, Department for Medicaid Services", December 2001[revision];

(b) "Home Health Services Manual", November 1993[edition];

(c) "Technical Criteria for Reviewing Ancillary Services for Adults", February 2000[Edition]; and

(d) "Technical Criteria for Reviewing Ancillary Services for Pediatrics", April 2000[Edition].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday 8 a.m. to 4:30 p.m.; or

(b) The Web site located at <http://www.chfs.ky.gov/dms/incorporated.htm>.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding home health services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding home health 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 Medicaid Program coverage provisions and requirements regarding home health services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital 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 primary amendment establishes a uniform limit of twenty (20) occupational therapy service visits, physical therapy service visits, or speech pathology service visits per recipient per calendar year. Additional services above the limit may be granted if additional services are determined to be medically necessary. This administrative regulation is being promulgated in conjunction with other administrative regulations - 907 KAR 8:010, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:020, Independent physical therapy service coverage provisions and requirements; 907 KAR 8:030, Independent speech pathology service coverage provisions and requirements; 907 KAR 10:014, Outpatient hospital services; and 907 KAR 3:005, Physician services – which will establish a uniform limit of twenty (20) therapy service visits per recipient per calendar year. Additional amendments include establishing that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to the same recipient by two (2) different providers at the same time; inserting records maintenance and relate confidentiality of medical records requirements; establishing that if third party liability exists for a given recipient that the provider is to bill the third party; establishing electronic signature requirements; and establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding.

(b) The necessity of the amendment to this administrative regulation: The Department for Medicaid Services (DMS) is establishing a limit of twenty (20) therapy service visits per recipient per calendar year across various programs in order to synchronize coverage with the "benchmark" or "benchmark equivalent plan" that DMS selected for a new eligibility group known as the "Medicaid expansion" group. States which grant eligibility to the expansion group are required (by the Affordable Care Act) to establish an alternative benefit plan (array of covered services including limits) for the group. The alternative benefit plan must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state

employer health coverage that is offered and generally available to state employees;

The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year, DMS is adopting the same limit including for recipients of home health services. The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Outpatient hospitals will be affected by the amendment as will Medicaid recipients who receive physical therapy services, speech pathology services, or occupational therapy services via the home health program. Currently, there are ninety-nine (99) home health agencies participating in the Medicaid Program. 379 Medicaid recipients received speech pathology services via the home health program in the most recently completed state fiscal year. 1,742 Medicaid recipients received physical therapy services via the home health program in the most recently completed state fiscal year. 883 Medicaid recipients received occupational therapy services via the home health program in the most recently completed state fiscal year.

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

(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 or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Home health agencies will benefit by being reimbursed by the Medicaid Program for services provided in accordance with the requirements.

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

(a) Initially: DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state

fiscal year DMS spent \$17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent \$5.9 million (state and federal funds combined.) Of the \$17.8 million spent by DMS on home health services, over \$104,000 (state and federal funds combined) was spent on occupational therapy services; over \$292,000 (state and federal funds combined) was spent on physical therapy services; and over \$41,000 was spent on speech pathology services. Of the \$5.9 million spent by MCOs in aggregate on home health services, over \$400,000 was spent on occupational therapy services; over \$678,000 was spent on physical therapy services; and over \$343,000 was spent on speech pathology services.

(b) On a continuing basis: Please see the response in (a).

(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 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: 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 the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.220.

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. Medicaid programs are required to cover "home health services (§440.70) to any individual entitled to skilled nursing facility services."

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? Some home health agencies may be owned by local government entities, but DMS is unable to accurately predict the impact of this amendment as revenues will depend on utilization of services. Given that more individuals will be eligible for Medicaid services (not as a result of this administrative regulation though) utilization is expected to increase; thus, an increase in revenues is a logical expectation.

(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? Please see the response to question (a).

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment. DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state fiscal year DMS spent \$17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent \$5.9 million (state and federal funds combined.) Of the \$17.8 million spent by DMS on home health services, over \$104,000 (state and federal funds combined) was spent on occupational therapy services; over \$292,000 (state and federal funds combined) was spent on physical therapy services; and over \$41,000 was spent on speech pathology services. Of the \$5.9 million spent by MCOs in aggregate on home health services, over \$400,000 was spent on occupational therapy services; over \$678,000 was spent on physical therapy services; and over \$343,000 was spent on speech pathology services.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional 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:

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Provider Operations

(Amendment)

907 KAR 1:038. Hearing Program coverage provisions and requirements[Hearing and Vision Program services].

RELATES TO: KRS 205.520, 334.010(4), (9), 334A.020(5), 334A.030, 42 C.F.R. 441.30, 447.53, 457.310, 42 U.S.C. 1396a, b, d, 1396r-6

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 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program provisions and requirements regarding the coverage of audiology services and hearing instruments[hearing services and vision services for which payment shall be made by the Medicaid Program].

Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

(2) ~~"Comprehensive choices" means a benefit plan for an individual who:~~

~~(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;~~

(b) ~~Receives services through either:~~
 1. ~~A nursing facility in accordance with 907 KAR 1:022;~~
 2. ~~The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;~~ 3. ~~The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or~~
 4. ~~The Model Waiver II Program in accordance with 907 KAR 1:595; and~~
 (c) ~~Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.~~
 (3)] "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.
 (3)](4)] "Department" means the Department for Medicaid Services or its designee.
 (4) "Enrollee" means a recipient who is enrolled with a managed care organization.
 (5) "Federal financial participation" is defined by 42 C.F.R. 400.203.
 (6) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or time.
 (7)](5) ~~"Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.~~
 (6) ~~"Family choices" means a benefit plan for an individual who:~~
 (a) ~~Is covered pursuant to:~~
 1. ~~42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;~~
 2. ~~42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);~~
 3. ~~42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);~~
 4. ~~42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);~~
 5. ~~42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or~~
 6. ~~42 C.F.R. 457.310; and~~
 (b) ~~Has a designated package code of 2, 3, 4, or 5.~~
 (7) ~~"Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:~~
 (a) ~~Caretaker relatives who:~~
 1. ~~Receive K-TAP benefits and are deprived due to death, incapacity, or absence;~~
 2. ~~Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or~~
 3. ~~Do not receive K-TAP benefits and are deprived due to unemployment;~~
 (b) ~~Individuals aged sixty-five (65) and over who receive SSI benefits and:~~
 1. ~~Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~
 2. ~~Receive SSP benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~
 (c) ~~Blind individuals who receive SSI benefits and:~~
 1. ~~Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~
 2. ~~SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~
 (d) ~~Disabled individuals who receive SSI benefits and:~~
 1. ~~Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or~~
 2. ~~SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~
 (e) ~~Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~
 (f) ~~Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet~~

nursing facility patient status in accordance with 907 KAR 1:022;
 (g) ~~Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;~~
 (h) ~~Pregnant women; or~~
 (i) ~~Medicaid works individuals.~~
 (8)] "Hearing instrument" is defined by KRS 334.010(4).
 (8) "Managed care organization" 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.
 (9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
 (10) "Recipient" is defined by KRS 205.8451(9).["Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53]
 (11) "Optimum choices" means a benefit plan for an individual who:
 (a) ~~Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;~~
 (b) ~~Receives services through either:~~
 1. ~~An intermediate care facility for individuals with an intellectual disability in accordance with 907 KAR 1:022; or~~
 2. ~~The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and~~
 (c) ~~Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.~~
 (12)] "Specialist in hearing instruments" is defined by KRS 334.010(9).

Section 2. General Requirements. (1)(a) For the department to reimburse for a service or item, the service or item shall:
 1. Be provided:
 a. To a recipient under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21); and
 b. By a provider who is:
 (i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;
 (ii) Currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and
 (iii) Authorized to provide the service in accordance with this administrative regulation;
 2. Be covered in accordance with this administrative regulation;
 3. Be medically necessary;
 4. Have a CPT code or HCPCS code that is listed on the Department for Medicaid Services Hearing Program Fee Schedule.
 (b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.
 (2)(a) If a procedure is part of a comprehensive service, the department shall:
 1. Not reimburse separately for the procedure; and
 2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.
 (b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.
 (3) A provider shall comply with:
 (a) 907 KAR 1:671;
 (b) 907 KAR 1:672; and
 (c) All applicable state and federal laws.
 (4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.
 (b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:
 1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(5)(a) An in-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license in accordance with KRS Chapter 334A;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department; and

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department.

(b) An out-of-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license to practice audiology in the state in which the audiologist is licensed;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association if the audiologist is out of state.

(c) If an audiologist fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the audiologist is in-state or out-of-state, the:

1. Audiologist shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the audiologist effective with the date the audiologist fails or failed to comply.

(6)(a) An out-of-state hearing instrument dispenser shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the licensing board with jurisdiction over hearing instrument dispensers in the state in which the license is held;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association.

(c) If a specialist in hearing instruments fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the specialist in hearing instruments is in-state or out-of-state, the:

1. Specialist in hearing instruments shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the specialist in hearing instruments effective with the date the specialist in hearing instruments fails or failed to comply.

Section 3. Audiology Services. (1) Audiology service[Hearing Services. (1) All hearing] coverage shall be limited to:

(a) A service provided:

1. To a recipient[Limited to an individual -] under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21); and

2. By an audiologist who:

a. Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

b. Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

c.(i) Meets the in-state audiologist requirements established in

Section 2(5)(a) of this administrative regulation if the audiologist is an in-state audiologist; or

(ii) Meets the out-of-state audiologist requirements established in Section 2(5)(b) of this administrative regulation if the audiologist is an out-of-state audiologist;

(b) A medically necessary service;

(c) One (1) complete hearing evaluation per calendar year; and

(d) A CPT code or HCPCS code listed on the Department for Medicaid Services Hearing Program Fee Schedule[-; and

(b) Provided in accordance with the Hearing Program Manual].

(2) Unless a recipient's health care provider demonstrates, and the department agrees, that an additional hearing instrument evaluation is medically necessary, a[services in excess of the limitations established in this subsection are medically necessary, reimbursement for services provided by an audiologist licensed pursuant to KRS 334A.030 to a recipient shall be limited to:

(a) The following procedures which shall be covered only if a recipient is referred by a physician to an audiologist licensed pursuant to KRS 334A.030:

Code	Procedure
92552	Pure Tone audiometry (threshold); air only
92555	Speech audiometry threshold
92556	Speech audiometry threshold; with speech recognition
92557	Comprehensive audiometry evaluation
92567	Tympanometry
92568	Acoustic reflex testing
92579	Visual reinforcement audiometry
92585	Auditory evoked potentials
92587	Evoked otoacoustic emissions
92588	Complete or diagnostic evaluation (comparison of transient or distortion product otoacoustic emissions at multiple levels and frequency)
92541	Spontaneous nystagmus test
92542	Positional nystagmus test
92543	Caloric vestibular test
92544	Optokinetic nystagmus test
92545	Oscillating tracking test
92546	Sinusoidal vertical axis rotational testing
92547	Use of vertical electrodes

(b) Complete hearing evaluation;

(e) hearing instrument evaluation shall:

(a) Be limited to being provided to an individual under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21);

(b) Include three (3) follow-up visits which shall be:

1. Within the six (6)-month period immediately following the fitting of a hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument; and

(c) Include one (1) additional follow-up visit which shall be;

(d) Three (3) follow-up visits that shall be:

1. Within the six (6)-month period immediately following fitting of a hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument; and

(e) One (1) additional follow-up visit that is:

1. At least six (6) months following the fitting of the hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument.

(3)(a) A referral by a physician to an audiologist shall be required for an audiology service.

(b) The department shall not cover an audiologist service if no referral from a physician to the audiologist was made.

Section 4. Hearing Instrument Coverage. [(3)] Hearing instrument benefit coverage shall:

(1) Be limited to a benefit;

(a) For an individual under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21);

(b) Provided by a specialist in hearing instruments or audiologist who meets the:

1. In-state specialist in hearing instruments requirements established in Section 2(6) of this administrative regulation if the specialist in hearing instruments is an in-state specialist in hearing instruments; or

2. Out-of-state audiologist requirements established in Section 2(6) of this administrative regulation if the audiologist is an out-of-state audiologist;

(c) That is medically necessary; and

(d) That has a corresponding HCPCS code listed on the Department for Medicaid Services Hearing Program Fee Schedule;

(2) If the benefit is a hearing instrument model, [(a)] be for a hearing instrument model that is:

(a)[1-] Recommended by an audiologist licensed pursuant to KRS 334A.030; and

(b)[2-] Available through a Medicaid-participating specialist in hearing instruments; and

(3)[(b)] Not exceed \$800 per ear every thirty-six (36) months; and

(c) Be limited to the following procedures:

Code	Procedure
V5010	Assessment for Hearing instrument
V5011	Fitting, Orientation, Checking of Hearing instrument
V5014	Repair, Modification of Hearing Instrument
V5015	Hearing Instrument Repair Professional Fee
V5020	Conformity Evaluation
V5030	Hearing Instrument, Monaural, Body Aid Conduction
V5040	Hearing Instrument, Monaural, Body Worn, Bone Conduction
V5050	Hearing Instrument, Monaural, In the Ear Hearing
V5060	Hearing Instrument, Monaural, Behind the Ear Hearing
V5070	Glasses; Air Conduction
V5080	Glasses; Bone Conduction
V5090	Dispensing Fee, Unspecified Hearing Instrument
V5095	Semi-Implantable Middle Ear Hearing Prosthesis
V5100	Hearing Instrument, Bilateral, Body Worn
V5120	Binaural; Body
V5130	Binaural; In the Ear
V5140	Binaural; Behind the Ear
V5150	Binaural; Glasses
V5160	Dispensing Fee, Binaural
V5170	Hearing Instrument, Cros, In the Ear
V5180	Hearing Instrument, Cros, Behind the Ear
V5190	Hearing Instrument, Cros, Glasses
V5200	Dispensing Fee, Cros
V5210	Hearing Instrument, Bicros, In the Ear
V5220	Hearing Instrument, Bicros, Behind the Ear
V5230	Hearing Instrument, Bicros, Glasses
V5240	Dispensing Fee, Bicros
V5241	Dispensing Fee, Monaural Hearing Instrument, Any Type
V5242	Hearing Instrument, Analog, Monaural, CIC (Completely In the Ear Canal)
V5243	Hearing Instrument, Analog, Monaural, ITC (In the Canal)
V5244	Hearing Instrument, Digitally Programmable Analog, Monaural, CIC
V5245	Hearing Instrument, Digitally Programmable Analog, Monaural, ITC
V5246	Hearing Instrument, Digitally Programmable Analog, Monaural, ITE (In the Ear)
V5247	Hearing Instrument, Digitally Programmable Analog, Monaural, BTE (Behind the Ear)
V5248	Hearing Instrument, Analog, Binaural, CIC
V5249	Hearing Instrument, Analog, Binaural, ITC
V5250	Hearing Instrument, Digitally Programmable Analog, Binaural, CIC
V5251	Hearing Instrument, Digitally Programmable Analog,

	Binaural, ITC
V5252	Hearing Instrument, Digitally Programmable, Binaural, ITE
V5253	Hearing Instrument, Digitally Programmable, Binaural, BTE
V5254	Hearing Instrument, Digital, Monaural, CIC
V5255	Hearing Instrument, Digital, Monaural, ITC
V5256	Hearing Instrument, Digital, Monaural, ITE
V5257	Hearing Instrument, Digital, Monaural, BTE
V5258	Hearing Instrument, Digital, Binaural, CIC
V5259	Hearing Instrument, Digital, Binaural, ITC
V5260	Hearing Instrument, Digital, Binaural, ITE
V5261	Hearing Instrument, Digital, Binaural, BTE
V5262	Hearing Instrument, Disposable, Any Type, Monaural
V5263	Hearing Instrument, Disposable, Any Type, Binaural
V5264	Ear Mold (One (1) Ear Mold Per Year Per Ear and if Medically Necessary)]
V5266	Hearing Instrument Battery (Limit of Four (4) Per Instrument When Billed With A New Hearing Instrument Or A Replacement Instrument)
V5267	Hearing Instrument Supplies, Accessories
V5299	Hearing Service Miscellaneous (May Be Used to Bill Warranty Replacement Hearing Instruments But Shall be Covered Only if Prior Authorized by the Department)]

Section 5. Replacement of a Hearing Instrument. (1) The department shall reimburse for the replacement of a hearing instrument if:

- (a) A loss of the hearing instrument necessitates replacement;
- (b) Extensive damage has occurred necessitating replacement;

or

(c) A medical condition necessitates the replacement of the previously prescribed instrument or equipment in order to accommodate a change in hearing loss.

(2) If replacement of a hearing instrument is necessary within twelve (12) months of the original fitting, the replacement hearing instrument shall be fitted upon the signed and dated recommendation from an audiologist.

(3) If replacement of a hearing instrument becomes necessary beyond twelve (12) months from the original fitting:

- (a) The recipient shall be examined by a physician with a referral to an audiologist; and
- (b) The recipient's hearing loss shall be re-evaluated by an audiologist.

Section 6. Noncovered services. The department shall not reimburse for:

- (1) A routine screening of an individual or group of individuals for identification of a hearing problem;
- (2) Hearing therapy except as covered through the six (6)-month adjustment counseling following the fitting of a hearing instrument;
- (3) Lip reading instructions except as covered through the six (6)-month adjustment counseling following the fitting of a hearing instrument;
- (4) A service for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment;
- (5) A telephone call;
- (6) A service associated with investigational research; or
- (7) A replacement of a hearing instrument for the purpose of incorporating a recent improvement or innovation unless the replacement results in appreciable improvement in the recipient's hearing ability as determined by an audiologist.

Section 7. Equipment. (1) Equipment used in the performance of a test shall meet the current standards and specifications established by the American National Standards Institute.

(2)(a) A provider shall ensure that any audiometer used by the provider or provider's staff shall:

1. Be checked at least once per year to ensure proper functioning; and

2. Function properly.

(b) A provider shall:

1. Maintain proof of calibration and any repair, if any repair occurs; and

2. Make the proof of calibration and repair, if any repair occurs, available for departmental review upon the department's request.

Section 8. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 9.[3. Vision Program Services. (1) Vision program coverage shall be limited to:

(a) A prescription service;

(b) A repair service made to a frame;

(c) A diagnostic service provided by:

1. An ophthalmologist; or

2. An optometrist to the extent the optometrist is licensed to perform the service.

(2) Eyeglass coverage shall:

(a) Be limited to a recipient who is under age twenty-one (21); and

(b) Not exceed:

1. \$200 per year for a recipient in the global choices benefit package; or

2. \$400 per year for a recipient in the comprehensive choices, family choices, or optimum choices benefit package.

(3) To be covered:

(a) A service designated as a physical medicine and rehabilitation service CPT code shall require prior authorization if provided to a recipient age twenty-one (21) or over;

(b) A radiology service specified in 907 KAR 3:005, Section 5, shall require prior authorization regardless of a recipient's age;

(c) A service shall be provided in accordance with the Vision Program Manual; and

(d) A lens shall be polycarbonate and scratch-coated.

Section 4. Appeal Rights.[4] An appeal of a negative action regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.[2] An appeal of a negative action regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.]

Section 10.[5.] Incorporation by Reference. (1) The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013,[following material] is incorporated by reference[:

(a) "The Vision Program Manual", October 2007 edition, Department for Medicaid Services; and

(b) "The Hearing Program Manual", October 2007 edition, Department for Medicaid Services].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A

public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(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 Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(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 Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

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

(a) How the amendment will change this existing administrative regulation: This amendment eliminates the definitions of and references to four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices; removes vision program provisions as they are being addressed in a separate administrative regulation; clarifies the age limit for audiology services; incorporates by reference a fee schedule which establishes the services with corresponding Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes covered by DMS; un-incorporates the Hearing Program Manual and inserts provisions from the manual into this administrative regulation; inserts program integrity requirements; inserts a section to address hearing instrument replacement; and establishes that the coverage provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding. Included in the existing vision provisions (all of which are being removed and inserted into a new administrative regulation - 907 KAR 1:632) are the \$200 and \$400 annual limits on eyewear. Those limits (along with all other vision provisions) are being deleted from this administrative regulation; however, those limits will not be included in the new vision services administrative regulation as annual dollar limits on benefits violates an Affordable Care Act mandate. This amended administrative regulation is being promulgated in concert with three (3) other related administrative regulations– 907 KAR 1:039, Hearing program reimbursement provisions and requirements; 907 KAR 1:631, Vision program reimbursement provisions and

requirements; and 907 KAR 1:632, Vision program coverage provisions and requirements.

(b) The necessity of the amendment to this administrative regulation: Eliminating the references to the four (4) benefit plans is necessary as DMS is eliminating the four (4) benefit plans [via a companion repealer administrative regulation which will repeal the administrative regulation (907 KAR 1:900, KyHealth Choices) which created the four (4) plans.] Eliminating provisions regarding vision service coverage is necessary as those provisions are being established in a new, separate administrative regulation; eliminating the manual previously incorporated by reference is necessary as provisions previously contained in the manual are being inserted into the body of this administrative regulation; and inserting program integrity requirements is necessary to enhance program integrity. Adopting a fee schedule is necessary to provide information in a reader friendly format for providers (via the fee schedule incorporated by reference.) Additionally, the \$200 and \$400 annual limits on eye glasses must be removed as a result of a federal mandate. The Affordable Care Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits." Medicaid benefits are within the scope of essential health benefits. Again, vision service provisions are being simultaneously established in a new and separate administrative regulation (907 KAR 1:632), but this amended administrative regulation had to be promulgated in concert with the new vision administrative regulation as this administrative regulation contained vision program provisions including the federally prohibited annual dollar limit. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by eliminating provisions regarding vision service coverage as they are being addressed in a separate administrative regulation; by inserting provisions from a manual previously incorporated by reference into the body of this administrative regulation; by enhancing program integrity; by providing information in a reader friendly format for providers; and by eliminating references to four (4) benefit plans which DMS is eliminating.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by eliminating provisions regarding vision service coverage as they are being addressed in a separate administrative regulation; by inserting provisions from a manual previously incorporated by reference into the body of this administrative regulation; by enhancing program integrity; by providing information in a reader friendly format for providers; and by eliminating references to four (4) benefit plans which DMS is eliminating.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: For calendar year 2012, eleven (11) specialists in hearing instruments billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and sixty-nine (69) audiologists billed the Medicaid program. 3,510 individuals (managed care and fee-for-service combined) received services from specialists in hearing instruments in calendar year 2012 and 3,236 individuals (managed care and fee-for-service combined) received services from audiologists during the same period.

(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 by the

amendment other than to properly bill for services and adhere to program integrity requirements.

(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 by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients will benefit due to the elimination of an annual dollar limit on eyeglasses. Medicaid providers may benefit from having a reader friendly fee schedule to view and from clarifications.

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(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 matching state funds appropriated in the biennium budget.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied as hearing services are limited to individuals under twenty-one (21) years of age as this is a component of mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services pursuant to 42 U.S.C. 1396d(r)(4) and 42 C.F.R. 441.56.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396d(r)(4), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 441.56, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. KRS 194A.050(1) states, "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 205.520(3) states: "... 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. EPDST hearing coverage must include at least testing and diagnosis and treatment for hearing defects, including hearing aids. Hearing services must also be, "provided—

(i) At intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition." Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are

required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services..." 45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

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. The requirements are not 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 (DMS) will be affected by this amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 441.56. and 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 will generate no revenue for DMS.

(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 will generate no revenue for DMS.

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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 Policy and Operations (Amendment)

907 KAR 1:039. Hearing Program reimbursement provisions and requirements[Payments for hearing services].

RELATES TO: KRS 205.520, 334.010, 334.040, 334.200, 334A.020(5), 42 C.F.R. 447.200, 204

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 Medicaid Program[~~of Medical Assistance~~]. 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the reimbursement provisions and requirements for covered audiology services, hearing instruments, and related items provided to a Medicaid recipient who is not enrolled with a managed care organization[method for determining amounts payable by the department for hearing services].

Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

(2) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology["Comparable instrument" means an instrument falling within the general classifications of fitting type, for example, body, behind the ear, in the ear, or eyeglasses].

(3) "Department" means the Department for Medicaid Services.

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

(5) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or time.

(6) "Hearing instrument" is defined by KRS 334.010(4).

(7) "Managed care organization" 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.

(8) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Participating audiologist" means an audiologist who:

(a) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(b) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(c) Meets the audiologist requirements established in 907 KAR 1:038.

(10) "Participating specialist in hearing instruments" means a specialist in hearing instruments who:

(a) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(b) Is currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(c) Meets the specialist in hearing instruments requirements established in 907 KAR 1:038.

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

(12)[(5)] "Specialist in hearing instruments" is defined by KRS 334.010(9).

(13) "Usual and customary charge" means the uniform amount that a provider bills to the general public for a specific covered benefit.

Section 2. General Reimbursement Requirements. (1)(a) For the department to reimburse for a service or item, the service or item shall be:

1. Provided:

a. To a recipient under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21); and

b. By a provider who is:

(i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Authorized to provide the service in accordance with 907 KAR 1:038;

2. Covered in accordance with 907 KAR 1:038; and

3. Medically necessary.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(3) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(4)(a) If a provider receives any duplicate or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(5) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Hearing Program Fee Schedule; or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Hearing Program Fee Schedule.

Section 3. Audiology Service Reimbursement. The department shall reimburse a participating audiologist for an audiology service at the lesser of the:

(1) Audiologist's usual and customary charge for the service; or

(2) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the service.

Section 4. Hearing Instrument Reimbursement. (1) The department shall reimburse a participating specialist in hearing instruments or participating audiologist for a hearing instrument at the lesser of the:

(a) Provider's usual and customary charge for the hearing instrument; or

(b) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the hearing instrument.

(2) A hearing examination of a recipient by a physician and a recommendation for a hearing instrument for the recipient by an audiologist shall:

(a) Be required for the department to cover a hearing instrument; and

(b) Occur prior to the fitting of a hearing instrument.

(3)(a) Except for an ear mold, an invoice for a hearing instrument, related supply, or accessory shall be submitted with the

corresponding claim:

1. To the department; and

2. By the participating audiologist or participating specialist in hearing instruments who supplied the hearing instrument, related supply, or accessory.

(b) The department shall not require a participating audiologist or participating specialist in hearing instruments to submit an invoice for an ear mold.

Section 5. Ear Mold Reimbursement. (1) The department shall reimburse a participating audiologist or participating specialist in hearing instruments for an ear mold at the lesser of the:

(a) Provider's usual and customary charge for the ear mold; or

(b) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the ear mold.

(2) The department shall limit reimbursement for an ear mold, in conjunction with an ear examination, to:

(a) One (1) ear mold per six (6) month period for a child aged three (3) years or under; or

(b) One (1) ear mold per twelve (12) month period for a child who is at least four (4) years of age.

Section 6. Reimbursement for Hearing Instrument Batteries.

(1) The department shall reimburse a participating audiologist or participating specialist in hearing instruments for a hearing instrument battery at the lesser of the:

(a) Provider's usual and customary charge for the hearing instrument battery; or

(b) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the hearing instrument battery.

(2) The department's reimbursement for hearing instrument batteries shall be limited to fifty-two (52) batteries per hearing instrument when dispensed with a:

(a) New hearing instrument; or

(b) Replacement hearing instrument.

Section 7. Replacement Cord Reimbursement. The department shall reimburse a participating audiologist or participating specialist in hearing instruments for a replacement cord at the lesser of the:

(1) Provider's usual and customary charge for the replacement cord; or

(2) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the replacement cord.

Section 8. Hearing Instrument Repair Reimbursement. The department shall reimburse a participating audiologist or participating specialist in hearing instruments for hearing instrument repair at the lesser of the:

(1) Provider's usual and customary charge for the hearing instrument repair; or

(2) Reimbursement established on the Department for Medicaid Services Hearing Program Fee Schedule for the hearing instrument repair.

Section 9. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for a service or item covered pursuant to 907 KAR 1:038 and this administrative regulation.

Section 10. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 11.[Section 2. Reimbursement to an Audiologist. The

department shall reimburse a participating audiologist at usual and customary actual billed charges up to the fixed upper limit per procedure established by the department at sixty-five (65) percent of the median billed charge using 1989 calendar year billed charges.

~~Section 3. Hearing Instrument Reimbursement. (1) If a manufacturer of a hearing instrument billed to the department submits a price schedule which includes the manufacturer's invoice price of the hearing instrument, the department shall reimburse the participating specialist in hearing instruments at the lesser of:~~

~~(a) The manufacturer's invoice price plus a professional fee of:~~
~~1. \$150 for the first (one (1) ear) hearing instrument; and~~
~~2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date;~~

~~(b) The actual specialist in hearing instruments' cost plus a professional fee of:~~

~~1. \$150 for the first (one (1) ear) hearing instrument; and~~
~~2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date; or~~

~~(c) The suggested retail price submitted by the manufacturer for the hearing instrument.~~

~~(2) If a manufacturer of a hearing instrument billed to the department has not submitted a price schedule which includes the manufacturer's invoice price for the hearing instrument, the department shall reimburse the participating specialist in hearing instruments at the lesser of:~~

~~(a) The lowest price submitted for a comparable hearing instrument plus a professional fee of:~~

~~1. \$150 for the first (one (1) ear) hearing instrument; and~~
~~2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two~~

~~(2) hearing instruments are dispensed on the same date;~~

~~(b) The actual specialist in hearing instruments' cost plus a professional fee of:~~

~~1. \$150 for the first (one (1) ear) hearing instrument; and~~
~~2. Fifty (50) dollars for the second (two (2) ears or binaural) hearing instrument if two (2) hearing instruments are dispensed on the same date; or~~

~~(c) The lowest suggested retail price submitted by a manufacturer for a comparable instrument.~~

~~Section 4. Replacement Cord Reimbursement. The department shall reimburse for a replacement cord at the specialist in hearing instruments' cost plus a professional fee set at \$21.50.~~

~~Section 5. Hearing Instrument Repair Reimbursement. The department shall reimburse a specialist in hearing instruments for a hearing instrument repair:~~

~~(1) On the basis of the manufacturer's charge for repair or replacement of parts;~~

~~(2) Plus the specialist in hearing instruments' cost for postage and insurance relative to the repair;~~

~~(3) Plus a professional fee of \$21.50; and~~

~~(4) Not to exceed the price of a new hearing instrument.~~

~~Section 6.] Appeals. A provider may appeal a department decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.~~

Section 12. Incorporation by Reference. (1) The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013, 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, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the reimbursement provisions for Medicaid hearing services and related.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to comply with federal and state laws that require provision of hearing services for the Kentucky Medicaid recipients who are eligible for hearing 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 hearing service reimbursement provisions.

(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 hearing service reimbursement 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: The amendment establishes that the coverage provisions are contingent upon the receipt of federal approval and federal funding; inserts program integrity requirements and safeguards; incorporates by reference a Hearing Program Fee Schedule which lists covered CPT codes and HCPCS codes along with corresponding reimbursements; eliminates the prior upper payment limit which was sixty-five (65) percent of the median billed charge (for a service) using 1989 calendar year billed charges; eliminates reimbursement provisions that are now addressed on the aforementioned fee schedule; clarifies that an individual remains eligible for services in the month that they become twenty-one (21); inserts requirements that were previously stated in a hearing services manual; inserts ear mold, hearing instrument, and hearing instrument battery reimbursement limits. This administrative regulation is being promulgated simultaneously with a companion administrative regulation (907 KAR 1:038E, Hearing program coverage provisions and requirements) necessary to be promulgated at the same time as this administrative regulation.

(b) The necessity of the amendment to this administrative regulation: Establishing that the provisions are contingent upon the receipt of federal approval and federal funding is necessary to prevent Kentucky taxpayer funds from being spent if federal matching funds are not being provided. The program integrity requirements/safeguards are necessary to ensure appropriate utilization of services and to protect the health, safety, and welfare of Medicaid recipients. The upper payment limit amendment is

necessary to equalize provider reimbursement among programs/provider types (physicians and audiologists); and incorporating the fee schedule offers providers a more reader-friendly mechanism for displaying reimbursement. This amended administrative regulation is being promulgated simultaneously with a companion administrative regulation (907 KAR 1:038E, Hearing Program coverage provisions and requirements) as the companion administrative regulation adopts the same fee schedule incorporated by reference into this administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by preventing a potential loss of state funds, by enhancing program integrity requirements and safeguards for Medicaid recipients, and by equalizing provider reimbursement among programs and provider types.

(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the authorizing statutes by preventing a potential loss of state funds, by enhancing program integrity requirements and safeguards for Medicaid recipients, and by equalizing provider reimbursement among programs and provider types.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: For calendar year 2012, eleven (11) specialists in hearing instruments billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and sixty-nine (69) audiologists billed the Medicaid program. 3,510 individuals (managed care and fee-for-service combined) received services from specialists in hearing instruments in calendar year 2012 and 3,236 individuals (managed care and fee-for-service combined) received services from audiologists during the same period.

(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 necessary to comply with the amendment other than to properly bill for services and adhere to program integrity requirements.

(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 by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Providers should benefit from the fee schedule as it's a more reader-friendly mechanism with which to view reimbursement. Recipients may benefit from the enhanced program integrity requirements and safeguards.

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(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 matching state funds appropriated in the biennium budget.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied as audiology service coverage and hearing instrument coverage are limited to individuals under twenty-one (21) years of age as this is a component of mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services pursuant to 42 U.S.C. 1396d(r)(4) and 42 C.F.R. 441.56(c)(1).

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396d(r)(4), 42 U.S.C. 1396a(a)(30)(A), and 42 C.F.R. 441.56.

2. State compliance standards. KRS 194A.050(1) states, "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."

3. Minimum or uniform standards contained in the federal mandate. EPDST hearing coverage must include at least testing and diagnosis and treatment for hearing defects, including hearing aids. Hearing services must also be, "provided—

(i) At intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) At such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition." Additionally, Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

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. The requirements are not stricter.

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) is affected by the administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 441.56(c)1.

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 anticipates no additional revenue being generated by 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 additional revenue being generated by the amendment.

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost \$6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid \$342,348 in claims to specialists in hearing instruments. For the same period DMS paid \$13,191 in claims to audiologists and Medicaid managed care organizations paid \$340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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 Community Alternatives
(Amendment)**

907 KAR 1:044. Coverage provisions and requirements regarding community mental health center services.

RELATES TO: KRS 194A.060, 205.520(3), 205.8451(9), 422.317, 434.840-434.860, 42 C.F.R. 415.208, 431.52, 431 Subpart F

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 210.450, 42 U.S.C. 1396a-d,

NECESSITY, FUNCTION, AND CONFORMITY: 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 any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the coverage provisions and requirements regarding[for] community mental health center (CMHC) services.

Section 1. Definitions. (1) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

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

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

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

(5) "Provider" is defined by KRS 205.8451(7).

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

Section 2. Requirements for a Psychiatric Nurse. A registered nurse employed by a participating community mental health center shall be considered a psychiatric or mental health nurse if the

individual[he or she]:

(1) Possesses a master of science in nursing with a specialty in psychiatric or mental health nursing;

(2)(a) Is a graduate of a four (4) year nursing educational program with a bachelor of science in nursing; and

(b) Possesses at least one (1) year of experience in a mental health setting;

(3)(a) Is a graduate of a three (3) year nursing educational program; and

(b) Possesses at least two (2) years of experience in a mental health setting;

(4)(a) Is a graduate of a two (2) year nursing educational program with an associate degree in nursing; and

(b) At least three (3) years of experience in a mental health setting; or

(5) Possesses any level of education with American Nursing Association certification as a psychiatric or mental health nurse.

Section 3. Community Mental Health Center Services Manual. The conditions for participation, services covered, and limitations for the community mental health center services component of the Medicaid Program shall be as specified in:

(1) This administrative regulation; and

(2) The Community Mental Health Center Services Manual.

Section 4. Covered Services. (1) Services covered pursuant to this administrative regulation and pursuant to the Community Mental Health Center Services Manual shall include:

(a) Inpatient services;

(b) Outpatient Services;

(c) Individual therapy;

(d) Group therapy;

(e) Family therapy;

(f) Collateral services including collateral therapy;

(g) Intensive in-home services;

(h) Home visits;

(i) Emergency services;

(j) Personal care home services;

(k) Therapeutic rehabilitation services for adults;

(l) Therapeutic rehabilitation services for children;

(m) Evaluations, examinations, and testing including psychological testing;

(n) Physical examinations;

(o) Services in a detoxification setting;

(p) Chemotherapy services;

(q) Screening;

(r) An assessment;

(s) Crisis intervention;

(t) Service planning;

(u) A screening, brief intervention, and referral to treatment;

(v) Medication assisted treatment for a substance use disorder;

(w) Mobile crisis services;

(x) Assertive community treatment;

(y) Intensive outpatient program services;

(z) Residential crisis stabilization services;

(aa) Partial hospitalization;

(bb) Residential services for substance use disorders;

(cc) Day treatment;

(dd) Comprehensive community support services;

(ee) Peer support services; or

(ff) Parent or family peer support services.

(2)(a) To be covered under this administrative regulation, a service listed in subsection (1) of this section shall be~~[inpatient services, outpatient services, therapeutic rehabilitation services, emergency services and personal care home services shall be covered if the service]:~~

1. [(+) Is] Provided by a community mental health center that is:

a. Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672; and

b. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and

2. [-] and

(2) Is] Provided in accordance with:

- a. This administrative regulation; and
- b. The Community Mental Health Center Services Manual.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 5. Electronic Documents and Signatures. (1) The creation, transmission, storage, or other use of electronic signatures and documents shall comply with requirements established in KRS 369.101 to 369.120 and all applicable state and federal laws and regulations.

(2) A CMHC choosing to utilize electronic signatures shall:

(a) Develop and implement a written security policy which shall:

- 1. Be complied with by each of the center's employees, officers, agents, and contractors; [and]
- 2. Stipulate which individuals have access to which electronic signatures and password authorization; and
- 3. Identify each electronic signature for which an individual has access;[:]

(b) Ensure that electronic signatures are created, transmitted and stored securely;[and]

(c) Develop a consent form which shall:

- 1. Be completed and executed by each individual utilizing 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

(d) 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 6. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independently enrolled behavioral health service provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a community mental health center.

Section 7. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2) A health record shall:

(a) Include:

1. An identification and intake record including:

- a. Name;
- b. Social Security number;
- c. Date of intake;
- d. Home (legal) address;
- e. Health insurance information;
- f. Referral source and address of referral source;
- g. Primary care physician and address;
- h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider; and

j. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

- (i) This administrative regulation;
- (ii) The provider's licensure board;
- (iii) State law; or
- (iv) Federal law;

2. Documentation of the:

- a. Screening;
- b. Assessment;
- c. Disposition; and
- d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;

3. A complete history including mental status and previous treatment;

4. An identification sheet;

5. A consent for treatment sheet that is accurately signed and dated; and

6. The individual's stated purpose for seeking services;

(b) Be:

- 1. Maintained in an organized central file;
- 2. Furnished to the Cabinet for Health and Family Services upon request;

3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;

4. Readily accessible; and

5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient; and

(c) Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(3) The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(4)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(5) A provider shall comply with 45 C.F.R. Part 164.

(6) Documentation of a screening shall include:

(a) Information relative to the individual's stated request for services; and

(b) Other stated personal or health concerns if other concerns are stated.

(7)(a) A provider's notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit; and

2. Describe the:

a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

b. Therapist's intervention;

c. Changes in the treatment plan if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional providing the service.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(8) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) An appropriate diagnosis;

(b) A referral for further consultation and disposition, if applicable; and

(c)1. Termination of services and referral to an outside source for further services; or

2. Termination of services without a referral to further services.

(9)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.

(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.

(10)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Dated;

3. Titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(11)(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

2. Contain a summary of the significant findings and events during the course of treatment including the:

a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

b. Final diagnosis of clinical impression; and

3. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(12) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(13) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient.

(14)(a) If a provider's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records of the provider shall:

1. Remain the property of the provider; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A provider shall have a written plan addressing how to maintain health records in the event of the provider's death.

Section 8. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 9. Provider Eligibility. (1) To be eligible to provide, and be reimbursed, for a service pursuant to this administrative regulation, a community mental health center shall be:

(a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

(b) Except as established in subsection (2) of this section, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671.

(2) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 10. Third Party Liability. A provider shall comply with KRS 205.622.

Section 11. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 12. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 13. Appeal Rights. (1) An appeal of an adverse action by the[a] department [decision] regarding a [Medicaid] recipient who is not enrolled with a managed care organization [based upon an application of this administrative regulation] shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:674].

Section 14.[7-] Incorporation by Reference. (1) The "Community Mental Health Center Services Manual", December 2013[January 2008 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, 6th Floor West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort,

Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program community mental health center (CMHC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program CMHC 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 coverage provisions and requirements regarding Medicaid Program CMHC 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 authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program CMHC 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 primary amendment authorizes CMHC to provide substance use disorder services (to all Medicaid recipients in contrast to the current scope of coverage which only includes pregnant women) and expands the scope of behavioral health services covered in a CMHC. Additional amendments include inserting various program integrity requirements such as requiring CMHCs to bill third parties for services if a third party is involved and not duplicate bill for a service provided to the recipient by another provider. Other amendments include establishing that CMHCs must comply with records maintenance/security requirements and Medicaid provider participation requirements. Another section is added to establish that the coverage of CMHC services is contingent upon federal approval and federal funding. Also, a section is added that clarifies that the Department for Medicaid Services has the authority to audit any claim, medical record, or documentation associated with any claim or medical record. Lastly, the appeals section is revised to establish that appeal rights regarding an adverse action in the realm of managed care will be as established in the relevant managed care organization administrative regulation (907 KAR 17:010, Managed care organization requirements and policies relating to enrollees.)

(b) The necessity of the amendment to this administrative regulation: The primary amendment – amendment related to substance use disorder services and behavioral health services – is necessary to comply with a federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." Additionally, the Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange. The Medicaid Program is required to ensure that recipients have access to services. Other amendments

are necessary to enhance program integrity requirements, establish that provisions and requirements are contingent upon federal funding (in order to protect state taxpayer generated funds), and clarify appeal rights for Medicaid recipients.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(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 complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Community mental health centers will be affected by this amendment. Additionally, licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide substance use disorder services or the enhanced behavioral health services (established in this amendment) while working for or under contract with CMHC will also be affected by this administrative regulation. Medicaid recipients who qualify for substance use disorder services or the enhanced scope of behavioral health services will be affected by this amendment.

(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. CMHCs will need to ensure that they use the practitioners authorized in this administrative regulation (stated in the incorporated material) to provide the new scope of services (expanded behavioral health services and substance use disorder services) if the given CMHCs wish to expand their scope of services accordingly.

(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 anticipated as expanding the scope of services is voluntary.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). CMHCs will benefit by being authorized to provide more services. The expanded types of behavioral health practitioners/professionals will benefit by having more employment opportunities in which to provide services. Medicaid recipients will benefit by having enhanced access to behavioral health services including substance use disorder services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services, including substance use disorder services, covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid program expenditures in

aggregate.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2).

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

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 the amendment to this administrative regulation as will any community mental health center owned by a local government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many community mental health centers that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid Program expenditures in aggregate.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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 Community Alternatives

(Amendment)

907 KAR 1:045. Reimbursement provisions and requirements regarding ~~Payments for~~ community mental health center services.

RELATES TO: KRS 205.520(3), 210.370

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 447.325, 42 U.S.C. 1396a-d

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services

has responsibility to administer the program of Medical Assistance. 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the reimbursement provisions and requirements regarding[method for determining amounts payable by the Medicaid Program for] community mental health center services provided to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. Definitions. (1) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

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

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Managed care organization" 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.

(6) "Provider" is defined by KRS 205.8451(7).

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

Section 2. General Reimbursement Provisions. (1) The department shall reimburse a[Community Mental Health Centers.] participating in-state community mental health center[centers shall be reimbursed] as established in this subsection.[follows:]

(a)[(1) Effective July 1, 2005] The payment rate that was in effect on June 30, 2002, for the community mental health center for community mental health center services shall remain in effect[throughout state fiscal year (SFY) 2006] and there shall be no cost settling.

(b)[(2)] Allowable costs shall not:

1. Exceed customary charges which are reasonable;

2. [(a) Allowable costs shall not] Include:

a. [1.] The costs associated with political contributions;

b. [2.] Travel or related costs for trips outside the state (for purposes of conventions, meetings, assemblies, conferences, or any related activities);

c. [3.] The costs of motor vehicles used by management personnel which exceed \$20,000 total valuation annually (unless the excess cost is considered as compensation to the management personnel); or

d. [4.] Legal fees for unsuccessful lawsuits against the cabinet.

(c)[(b)] Costs (excluding transportation costs) for training or educational purposes outside the state shall be allowable costs.

(2) To be reimbursable, a service shall be:

(a) Provided:

1. By a CMHC:

a. That is currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

b. Except as established in subsection (3) of this section, that is currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and

2. To a recipient:

(b) Medically necessary; and

(c) A covered CMHC service pursuant to 907 KAR 1:044.

(3) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 3.[2.] Implementation of Payment System. (1)(a) Payments shall be based on units of service.

(b) One (1) unit for each service shall be defined as follows:

Service	Unit of Service
Inpatient Service	15 minutes

Outpatient Service	15 minutes
Individual Therapy	15 minutes
Group Therapy	15 minutes
Family Therapy	15 minutes
Collateral Therapy	15 minutes
Intensive In-Home Services[Therapy]	15 minutes
Home Visit Service	15 minutes
Emergency Service	15 minutes
Personal Care Home Service	15 minutes
Evaluations, Examinations, and Testing including Psychological Testing	15 minutes
Therapeutic Rehabilitation for Children	1 hour
Therapeutic Rehabilitation for Adults	1 hour
Chemotherapy Service	15 minutes
Physical Examinations	15 minutes
Services in a Detoxification Setting	15 minutes
Screening	15 minutes
Assessment	15 minutes
Crisis Intervention	15 minutes
Service Planning	15 minutes
Screening, Brief Intervention, and Referral to Treatment	15 minutes
Medication Assisted Treatment for a Substance Use Disorder	15 minutes
Mobile Crisis Services	15 minutes
Assertive Community Treatment	15 minutes
Intensive Outpatient Program Services	15 minutes
Residential Crisis Stabilization Services	15 minutes
Residential Services for Substance Use Disorders	15 minutes
Partial Hospitalization	15 minutes
Day Treatment	15 minutes
Comprehensive Community Support Services	15 minutes
Peer Support Services	15 minutes
Parent or Family Peer Support Services	15 minutes

(2) An initial unit of service which lasts less than fifteen (15) minutes may be billed as one (1) unit.

(3) Except for an initial unit of a service, a service that is:

(a) Less than one-half (1/2) of one (1) unit shall be rounded down; or

(b) Equal to or greater than one-half (1/2) of one (1) unit shall be rounded up.

(4) An individual provider shall not exceed four (4) units of service in one (1) hour.

(5) An overpayment[Overpayments] discovered as a result of an audit[audit] shall be settled through recoupment or withholding.

(6) A community mental health center[The vendor] shall:

(a) Complete an annual cost report on forms provided by the department [cabinet] (and included in the Community Mental Health Center[Intellectual Disability] Reimbursement Manual;

(b) No[not] later than ninety (90) days from the end of the community mental health center's[vendor's] accounting year, submit the cost report to the department; and

(c)[the vendor shall] Maintain an acceptable accounting system to account for:

1. The cost of total services provided;

2. [.] Charges for total services rendered;[.] to] and

3. Charges for covered services rendered eligible recipients.

(7) A[Each] community mental health center shall make available to the department all recipient records and fiscal records:

(a)[cabinet] At the end of each fiscal reporting period;

(b) Upon request by[, and at intervals as] the department; and

(c)[cabinet may require, all patient and fiscal records of the provider.] Subject to reasonable prior notice by the department[cabinet].

(8) Payments due a community mental health center shall be made at least once a month[reasonable intervals but not less often than monthly].

Section 4.[3.] Nonallowable Costs. The department[cabinet]

shall not reimburse:

(1) ~~make reimbursement~~ Under the provisions of this administrative regulation for a service that is ~~services~~ not covered by 907 KAR 1:044; or

(2) ~~For~~ ~~mental health center services, nor for that portion of~~ a community mental health center's costs found unreasonable or nonallowable in accordance with the ~~Community Mental Health Center~~ ~~Intellectual Disability~~ Reimbursement Manual~~["]~~.

Section 5.4. Reimbursement of Out-of-state Providers. Reimbursement to a participating out-of-state community mental health center~~centers~~ shall be the:

(1) Lower of charges;

(2) ~~or the~~ Facility's rate as set by the state Medicaid Program in the other state; ~~or~~

(3) ~~the~~ Upper limit for that type of service in effect for Kentucky providers.

Section 6.5. Appeal Rights. A community mental health center~~provider~~ may appeal a Department for Medicaid Services decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 7.6. Not Applicable to Managed Care Organization. A managed care organization shall not be required to reimburse for community mental health center services in accordance with this administrative regulation.

Section 8. Federal Approval. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 9. Incorporation by Reference. (1) The "Community Mental Health Center~~Intellectual Disability~~ Reimbursement Manual", December 2013~~July 2005 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., or 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 27, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Suite B, of the Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid Program reimbursement provisions and requirements regarding community mental health center (CMHC) services. CMHCs operate under the authority of regional community mental health boards [there are fourteen (14) in Kentucky] - in accordance with KRS 210.370 through KRS 210.485 - and are licensed and regulated by the Cabinet for Health and Family Services, Office of Inspector General.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Kentucky Medicaid program reimbursement provisions and requirements regarding CMHC 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 Kentucky Medicaid program reimbursement provisions and requirements regarding CMHC 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 authorizing statutes by establishing the Kentucky Medicaid program reimbursement provisions and requirements regarding CMHC 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 adds reimbursement for services (added to companion administrative regulation 907 KAR 1:044, Community mental health center services) not previously included in the scope of Medicaid CMHC services. Among the new services are substance use disorder services for all ages/categories of Medicaid recipients. Previously, the Department for Medicaid Services (DMS) only covered substance use treatment for pregnant women and children. The amendment also adds other new behavioral health services not previously covered by the Medicaid program and clarifies that the reimbursement rates for CMHC services remains in effect at the same level.

(b) The necessity of the amendment to this administrative regulation: The amendment is necessary to establish reimbursement for new services being added to the scope of CMHC services covered by the Medicaid Program including substance use disorder services for all ages/categories of Medicaid recipients. Previously, the Department for Medicaid Services (DMS) only covered substance use treatment for pregnant women and children; however, the Affordable Care Act mandates Medicaid coverage of substance use disorder services for all; thus, the amendment is necessary to comply with a federal mandate.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with a federal mandate.

(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 complying with a federal mandate.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The amendment applies to all CMHCs. There are currently fifteen (15) CMHCs participating in the Medicaid Program. 73,779 Medicaid recipients received CMHC services during the course of the state fiscal year that ended June 30, 2013 with CMHCs receiving a total of \$21.9 million from DMS for the services and \$38.86 million from managed care organizations for the 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. No compliance action is mandated.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This amendment imposes no cost on the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): CMHCs will benefit by reimbursed for more services covered by the Medicaid program and recipients will benefit by having access to more CMHC services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services, including substance use disorder services, covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid program expenditures in aggregate.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 will be necessary to implement the amendment to this administrative regulation.

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

(9) Tiering: Is tiering applied? Tiering is not applied as the amendment applies to all regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30) and 42 C.F.R. 447.204.

2. State compliance standards. KRS 205.520(3) states, "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. 42 U.S.C. 1396a(a)(30) requires Medicaid program payments to be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the same geographic area. 42 C.F.R. 447.204 requires Medicaid reimbursement to be sufficient to enlist enough providers to ensure that services are available to Medicaid recipients at least to the extent that they are available to the general population.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The policy is not stricter than the federal standard.

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 the amendment to this administrative regulation as will any community mental health center owned by a local government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many community mental health centers that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid program expenditures in aggregate.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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 Policy and Operations (Amendment)

907 KAR 1:054. Coverage provisions and requirements regarding federally-qualified health center services, federally-qualified health center look-alike services, and primary care center[and federally-qualified health center] services.

RELATES TO: KRS 205.520, 310.005, 314.011, 335.100, 42 C.F.R. 400.203, 405.2401, 2412-2416, 2446, 2448, 2450, 2452, 441 Subpart E and F, 447.53, 42 U.S.C. 1395x(aa), 42 U.S.C. 1396d

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 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program coverage provisions and requirements relating to primary care center and federally-qualified health center services[for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy].

Section 1. Definitions. (1) "Advanced practice registered nurse[practitioner]" is defined by KRS 314.011(7).

(2) "Certified social worker" means an individual who:

(a) Meets the requirements established in KRS 335.080; and

(b) Has at least a master's degree in social work.

(3) "Clinical pharmacist" means a licensed pharmacist whose scope of service includes taking medication histories, monitoring drug use, contributing to drug therapy, drug selection, patient counseling, administering drug programs, or surveillance for adverse reactions and drug interactions.

(4)[(3)] "Clinical psychologist" means a doctorate level psychologist who is licensed in accordance with KRS 319.050.

(5) "Club house model of psychosocial rehabilitation" means a form of psychosocial rehabilitation that focuses on self-help, friendship, emotional support, acceptance, and meaningful and gainful employment.

(6) "Community support associate" means an individual who meets the community support associate requirements established in 908 KAR 2:250.

(7)[(4)] "Department" means the Department for Medicaid Services or its designee.

(8)[(5)] "Emergency condition" means a condition or situation requiring an emergency service pursuant to 42 C.F.R. 447.53.

(9) "Enrollee" means a recipient who is enrolled with a managed care organization.

(10) "Face-to-face" means occurring:

(a) In person; or

(b) Via a real-time, electronic communication that involves two (2) way interactive video and audio communication.

(11) "Family peer support specialist" means an individual who meets the requirements for a Kentucky family peer support specialist established in 908 KAR 2:230.

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

(13)[(6)] "Federally-qualified health center" or "FQHC" is defined by 42 U.S.C. 1396d(l)(2)(B).

(14) "Federally-qualified health center look-alike" or "FQHC look-alike" means an entity that is currently approved by the United States Department of Health and Human Services, Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services to be a federally-qualified health center look-alike.

(15) "Fountain House" means the professional self-help program located in New York City about which information is available on the Web site of <http://www.fountainhouse.org/>.

(16)[(7)] "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(17) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(18) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(19) "Licensed professional counselor associate" is defined by KRS 335.500(3).

(20) "Licensed psychological associate" means an individual who:

(a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.

(21) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(22) "Licensed psychologist" means an individual who:

(a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

(23) "Managed care organization" 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.

(24) "Marriage and family therapy associate" is defined by KRS 335.300(3).

(25) "Medically necessary" means that a covered benefit or service is necessary in accordance with 907 KAR 3:130.

(26)[(8)] "Nurse-midwife" is defined by 42 C.F.R. 405.2401(b).

(27)[(9)] "Nutritionist" is defined by KRS 310.005(4).

(28) "Peer support specialist" means an individual who meets the peer specialist qualifications established in 908 KAR 2:220.

(29)[(10)] "Physician" is defined by KRS 205.510(11) and 42 C.F.R. 405.2401(b).

(30)[(11)] "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(31)[(12)] "Primary care center" or "PCC" means an entity meeting the primary care center requirements established in 902 KAR 20:058.

(32) "Qualified mental health professional" is defined by KRS 202A.011(12).

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

(34)[(13)] "State plan" is defined by 42 C.F.R. 400.203.

(35) "Youth peer support specialist" means an individual who meets the requirements established for a Kentucky youth peer support specialist established in 908 KAR 2:240.

Section 2. Primary Care Center Covered Services Other Than Behavioral Health Services. (1) The department shall cover, and a primary care center shall provide, the following services:

(a) Medical diagnostic or treatment services provided by a physician, advanced registered nurse practitioner, or a physician assistant if licensed under state authority;

(b) Treatment of injuries or minor trauma;

(c) Prenatal or postnatal care;

(d) Preventive health services including well-baby care, well-child care, immunization, or other preventive care;

(e) Referral services designed to ensure the referral to and acceptance by an appropriate medical resource if services necessary to the health of the patient are not provided directly by the center; and

(f) Health education, including distribution of written material, provided by appropriate personnel to local school systems, civic organizations, or other concerned local groups.

(2) The department shall cover the following services and a primary care center shall provide at least two (2) of the following services:

(a) Dental services;

(b) Optometric services;

(c) Family planning services listed and as limited in 907 KAR 1:048;

(d) Home health services listed and as limited in 907 KAR 1:030;

(e) Social services counseling;

(f) Pharmacy services which shall meet the coverage criteria established in 907 KAR 1:019;

(g) Nutritional services provided by a nutritionist, including individual counseling relating to nutritional problems or nutritional education or group nutritional services; or

(h) Nurse midwifery services which shall be provided:

1. As a program including prenatal services to expectant mothers, delivery or postnatal services; and

2. By a nurse midwife.

(3) The department shall cover, and a primary care center may provide the following services:

(a) Excluding institutional care, other state plan services;

(b) Holding or observation accommodations;

(c) Outreach services provided as a package structured to identify health care needs in the service area;

(d) Clinical pharmacist services; or

(e) ~~Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced registered nurse practitioner within the provider's legally authorized scope of service;~~

(f) Services or supplies furnished as an incident to services provided by a physician, physician assistant, advanced practice registered nurse [practitioner], or nurse midwife if the service or supply meets the criteria established in 42 C.F.R. 405.2413 or 42 C.F.R. 405.2415; or

(g) ~~Services or supplies incidental to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in 42 C.F.R.]~~

Section 3. Federally-Qualified Health Center and Federally-Qualified Health Center Look-Alike Covered Services Other Than Behavioral Health Services. A federally-qualified health center shall provide:

(1) Federally-qualified health center services pursuant to 42 U.S.C. 1395x(aa)(3);

(2) Federally-qualified health center services pursuant to 42 U.S.C. 1396d(l)(2)(A);

(3) Other Medicaid-covered ambulatory outpatient services established in the state plan; or

(4) Any combination of the services described in subsections (1), (2), and (3) of this section.

Section 4. Primary Care Center, Federally-Qualified Health Center, and Federally-Qualified Health Center Look-Alike Covered Behavioral Health Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for a:

(a) Mental health disorder;

(b) Substance use disorder; or

(c) Co-occurring mental health and substance use disorders.

(2) The department shall cover, and a primary care center, federally-qualified health center, or federally-qualified health center look-alike may provide, the following services:

(a) Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced registered nurse practitioner within the provider's legally authorized scope of service; or

(b) Services or supplies incidental to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in 42 C.F.R. 405.2452.

(3) In addition to the services referenced in subsection (2) of this section, the following behavioral health services provided by a primary care center, federally-qualified health center, or federally-qualified health center look-alike shall be covered under this administrative regulation in accordance with the corresponding following requirements:

(a) A screening provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the

licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(b) An assessment provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(c) Psychological testing provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner; or

3. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

(d) Crisis intervention provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(e) Service planning provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(r) Residential crisis stabilization provided by a team of at least two (2) of the following:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(s) Residential services for substance use disorders provided by a team of at least two (2) of the following:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the

service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(t) Therapeutic rehabilitation program services provided by a team of at least two (2) of the following individuals:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional; or

(u) Parent or family peer support provided by:

1. A peer support specialist working under the supervision of a mental health professional;

2. A family peer support specialist working under the supervision of a mental health professional; or

3. A youth peer support specialist working under the supervision of a mental health professional.

(4)(a) A screening shall:

1. Be the determination of the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorder;

2. Not establish the presence or specific type of disorder; and

3. Establish the need for an in-depth assessment.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the provider to:

a. Establish the presence or absence of a mental health disorder or substance use disorder;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinic disorder or service need;

3. Include working with the individual to develop a treatment and service plan; and

4. Not include a psychological or psychiatric evaluation or assessment.

(c) Psychological testing shall include:

1. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and

2. Interpretation and a written report of testing results.

(d) Crisis intervention:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:

a. The recipient; or

b. Another individual;

2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for an individual with a behavioral health disorder;

3. Shall be provided:

a. In an office, home, or community setting where the individual is experiencing the crisis;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one-on-one encounter between the provider and the recipient;

4. May include verbal de-escalation, risk assessment, or cognitive therapy; and

5. Shall be followed by a referral to noncrisis services if applicable.

(e)1. Service planning shall consist of assisting a recipient in creating an individualized plan for services needed to maintain functional stability or return to stability as soon as possible in order to avoid out-of-home care.

2. A service plan:

a. Shall be directed by the recipient; and

b. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

(f) Individual outpatient therapy shall:

1. Be provided to promote the:

a. Health and wellbeing of the individual; or

b. Recovery from a substance related disorder;

2. Consist of:

a. A face-to-face, one-on-one encounter between the provider and recipient; and

b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

a. Reducing adverse symptoms;

b. Reducing or eliminating the presenting problem of the recipient; and

c. Improving functioning; and

4. Not exceed three (3) hours per day.

(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

(h)1. Group outpatient therapy shall:

a. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Recovery from a substance related disorder;

b. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

c. Be provided to a recipient in a group setting:

(i) Of nonrelated individuals; and

(ii) Not to exceed eight (8) individuals in size;

d. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

e. Not include physical exercise, a recreational activity, an

educational activity, or a social activity; and

f. Not exceed three (3) hours per day.

2. The group shall have a:

a. Deliberate focus; and

b. Defined course of treatment.

3. The subject of a group receiving group outpatient therapy shall be related to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.

(i)1. Collateral outpatient therapy shall:

a. Consist of a face-to-face behavioral health consultation;

(i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and

(ii) That is provided in accordance with the recipient's treatment plan; and

b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age.

2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.

(i) Screening, brief intervention, and referral to treatment for a substance use disorder shall:

1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and

2. Consist of:

a. Using a standardized screening tool to assess an individual for risky substance use behavior;

b. Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and

c. Referring a recipient to:

(i) Therapy; or

(ii) Other additional services to address substance use if the recipient is determined to need other additional services.

(k) Medication assisted treatment for a substance use disorder:

1. Shall include:

a. Any opioid addiction treatment that includes a United States Food and Drug Administration-approved medication for the detoxification or maintenance treatment of opioid addiction along with counseling or other supports;

b. Comprehensive maintenance;

c. Medical maintenance;

d. Interim maintenance;

e. Detoxification; or

f. Medically supervised withdrawal;

2. May be provided in:

a. An opioid treatment program;

b. A medication unit affiliated with an opioid treatment program;

c. A physician's office; or

d. Other community setting; and

3. Shall increase the likelihood for cessation of illicit opioid use or prescription opioid abuse.

(l)1. Day treatment shall be a nonresidential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:

a. An emotional disability or neurobiological or substance use disorder; and

b. A high risk of out-of-home placement due to a behavioral health issue.

2. Day treatment services shall:

a. Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorder);

b. Have unified policies and procedures that:

(i) Address the program philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning; and

(ii) Have been approved by the recipient's local education

authority and the day treatment provider:

c. Include:

(i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

(ii) Behavior management and social skill training;

(iii) Independent living skills that correlate to the age and development stage of the recipient; or

(iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and

d. Be provided:

(i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);

(ii) On school days and during scheduled breaks;

(iii) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;

(iv) Under the supervision of a licensed or certified behavioral health practitioner or a behavioral health practitioner working under clinical supervision; and

(v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.

3. To provide day treatment services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. The capacity to employ staff authorized to provide day treatment services in accordance with subsection (3)(l) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in subparagraph 1 of this paragraph;

c. Demonstrated experience in serving individuals with behavioral health disorders;

d. The administrative capacity to ensure quality of services;

e. A financial management system that provides documentation of services and costs;

f. The capacity to document and maintain individual case records; and

g. Knowledge of substance use disorders.

4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.

(m)1. Comprehensive community support services shall:

a. Be activities necessary to allow an individual to live with maximum independence in community-integrated housing;

b. Be intended to ensure successful community living through the utilization of skills training, cueing, or supervision as identified in the recipient's treatment plan;

c. Include:

(i) Reminding a recipient to take medications and monitoring symptoms and side effects of medications; or

(ii) Teaching parenting skills, teaching community resource access and utilization, teaching emotional regulation skills, teaching crisis coping skills, teaching how to shop, teaching about transportation, teaching financial management, or developing and enhancing interpersonal skills; and

d. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

3. To provide comprehensive community support services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. The capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (3)(m) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;

c. Demonstrated experience in serving individuals with behavioral health disorders;

d. The administrative capacity to ensure quality of services;

e. A financial management system that provides documentation of services and costs; and

f. The capacity to document and maintain individual case records.

(n)1. Peer support services shall:

a. Be social and emotional support that is provided by an individual who is experiencing a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified consumer or parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:220;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide peer support services, an FQHC, an FQHC look-alike, or a PCC shall:

a. Have demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220;

c. Use a qualified mental health professional to supervise peer support specialists;

d. Have the capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (3)(n) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(o)1. Mobile crisis services shall:

a. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the year; and

b. Be a crisis response in a home or community setting to provide an immediate evaluation, triage, and access to acute substance use disorder services including treatment and supports to:

(i) Reduce symptoms or harm; or

(ii) Safely transition an individual in an acute crisis to appropriate crisis stabilization and detoxification supports or services.

2. To provide mobile crisis services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. The capacity to employ staff authorized to provide mobile crisis services in accordance with subsection (3)(o) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;

c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;

d. Demonstrated experience in serving individuals with behavioral health disorders;

e. The administrative capacity to ensure quality of services;

f. A financial management system that provides documentation of services and costs;

g. The capacity to document and maintain individual case records; and

h. Knowledge of substance use disorders.

(p)1. Assertive community treatment shall:

a. Be an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for individuals with a serious mental illness;

b. Use a multidisciplinary team of at least two (2) of the following professionals:

(i) A psychiatrist;

(ii) A nurse;

(iii) A case manager; or

(iv) A therapist; and

c. Include:

(i) Assessment;

(ii) Treatment planning;

(iii) Case management;

(iv) Psychiatric services;

(v) Medication management administration;

(vi) Individual outpatient therapy;

(vii) Family outpatient therapy;

(viii) Group outpatient therapy;

(ix) Mobile crisis intervention;

(x) Mental health consultation; or

(xi) Family support and basic living skills.

2. To provide assertive community treatment services, an FQHC, an FQHC look-alike, or a PCC shall:

a. Employ one (1) or more teams:

(i) Led by a qualified mental health professional; and

(ii) Comprised of at least four (4) full-time equivalents including a prescriber, a nurse, a qualified mental health professional, a case manager, or a co-occurring disorder specialist;

b. Have adequate staffing to ensure that no caseload size exceeds ten (10) participants per team member;

c. Have the capacity to employ staff authorized to provide assertive community treatment services in accordance with subsection (3)(p) of this section and to coordinate the provision of services among team members;

d. The capacity to provide the full range of assertive community treatment services as stated in this paragraph;

e. Demonstrated experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community;

f. The administrative capacity to ensure quality of services;

g. A financial management system that provides documentation of services and costs; and

h. The capacity to document and maintain individual case records.

(q)1. Intensive outpatient program services shall:

a. Be an alternative to inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;

b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy; and

c. Be provided at least three (3) hours per day at least three (3) days per week; and

d. Include:

(i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless contraindicated;

(ii) Crisis intervention; or

(iii) Psycho-education.

2. During psycho-education, the recipient or family member shall be:

a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and

b. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

3. An intensive outpatient program treatment plan shall:

a. Be individualized; and

b. Focus on stabilization and transition to a lesser level of care.

4. To provide intensive outpatient program services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. Access to a board-certified or board-eligible psychiatrist for consultation;

b. Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;

c. Adequate staffing to ensure a minimum recipient-to-staff ratio of four (4) clients to one (1) recipient;

d. The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;

e. The capacity to employ staff authorized to provide intensive outpatient program services in accordance with subsection (3)(g) of this section and to coordinate the provision of services among team members;

f. The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;

g. Demonstrated experience in serving individuals with behavioral health disorders;

h. The administrative capacity to ensure quality of services;

i. A financial management system that provides documentation of services and costs; and

j. The capacity to document and maintain individual case records.

(r)1. Residential crisis stabilization services shall be provided in a crisis stabilization unit.

2. A crisis stabilization unit shall:

a. Be a community-based, residential program that offers an array of services including:

(i) Screening;

(ii) Assessment;

(iii) Treatment planning;

(iv) Individual outpatient therapy;

(v) Family outpatient therapy;

(vi) Group outpatient therapy; and

(vii) Psychiatric services;

b. Provide services in order to:

(i) Stabilize a crisis and divert an individual from a higher level of care;

(ii) Stabilize an individual and provide treatment for acute withdrawal, if applicable; and

(iii) Re-integrate the individual into the individual's community or other appropriate setting in a timely fashion;

c. Not be part of a hospital;

d. Be used when an individual:

(i) Is experiencing a behavioral health emergency that cannot be safely accommodated within the individual's community; and

(ii) Needs overnight care that is not hospitalization;

e. Not contain more than sixteen (16) beds; and

f. Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

3. Residential crisis stabilization shall not include:

a. Room and board;

b. Educational services;

c. Vocational services;

d. Job training services;

e. Habilitation services;

f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

h. Recreational activities;

i. Social activities; or

j. Services required to be covered elsewhere in the state plan.

4. To provide residential crisis stabilization services, an FQHC, an FQHC look-alike, or a PCC shall have:

a. The capacity to employ staff authorized to provide residential crisis stabilization in accordance with subsection (3)(r) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year

basis:

c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;

d. Demonstrated experience in serving individuals with behavioral health disorders;

e. The administrative capacity to ensure the quality of services;

f. A financial management system that provides documentation of services and costs;

g. The capacity to document and maintain individual case records; and

h. Knowledge of substance use disorders.

(s)1. Residential services for substance use disorders shall:

a. Be provided in twenty-four (24) hour per day units;

b. Be short or long term to provide intensive treatment and skills building in a structured and supportive environment;

c. Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;

d. Be provided in a twenty-four (24) hour a day, live-in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring mental health and substance use disorders;

e. Assist a recipient in making necessary changes in the recipient's life to enable the recipient to live drug- or alcohol-free;

f. Last less than thirty (30) days;

g. Be provided under the medical direction of a physician;

h. Provide continuous nursing services;

i. Be based on individual need and may include:

(i) Screening;

(ii) Assessment;

(iii) Service planning;

(iv) Individual outpatient therapy;

(v) Group outpatient therapy; or

(vi) Family outpatient therapy; and

j. Be provided in accordance with 908 KAR 1:370.

2. A residential service for substance use disorder building shall have more than eight (8) but less than seventeen (17) beds.

3. A short-term length-of-stay for residential services for substance use disorders shall:

a. Be between fourteen (14) and twenty-eight (28) days in duration;

b. Include planned clinical program activities constituting at least fifteen (15) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize and maintain a person's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.i. of this paragraph.

4. A long-term length-of-stay for residential services for substance use disorders shall:

a. Be between twenty-eight (28) days and ninety (90) days in duration;

b. Include planned clinical program activities constituting at least forty (40) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize and maintain a person's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.i. of this paragraph.

5. Residential services for a substance use disorder shall not include:

a. Room and board;

b. Educational services;

c. Vocational services;

d. Job training services;

e. Habilitation services;

f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

h. Recreational activities;

i. Social activities; or

j. Services required to be covered elsewhere in the state plan.

6. The physical structure in which residential services for a substance use disorder are provided shall not:

a. Contain more than sixteen (16) beds; and

b. Be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

7. To provide residential services for a substance use disorder, an FQHC, an FQHC look-alike, or a PCC shall:

a. Have the capacity to employ staff authorized to provide residential services for substance use disorders in accordance with subsection (3)(s) of this section and to coordinate the provision of services among team members;

b. Have the capacity to provide the full range of residential services for a substance use disorder as stated in this paragraph;

c. Have demonstrated experience in serving individuals with behavioral health disorders;

d. Have the administrative capacity to ensure quality of services;

e. Have a financial management system that provides documentation of services and costs;

f. Have the capacity to document and maintain individual case records; and

g. Be licensed as a nonmedical and nonhospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370.

(t)1. Therapeutic rehabilitation program services shall:

a. Occur at the provider's site or in the community;

b. Be provided to an adult with a severe mental illness or to a child (under the age of twenty-one (21) years) to enhance skills and offer experiential learning opportunities that are aligned with treatment goals and recovery principles;

c. Not be a residential program; and

d. Be a day program based on the Fountain House clubhouse model of psychosocial rehabilitation for individuals with a serious mental illness.

2. To provide therapeutic rehabilitation program services, an FQHC, an FQHC look-alike, or a PCC shall:

a. Have the capacity to employ staff authorized to provide therapeutic rehabilitation program services in accordance with subsection (3)(t) of this section and to coordinate the provision of services among team members;

b. Have the capacity to provide the full range of therapeutic rehabilitation program services as stated in this paragraph;

c. Have demonstrated experience in serving individuals with mental health disorders;

d. Have the administrative capacity to ensure quality of services;

e. Have a financial management system that provides documentation of services and costs; and

f. Have the capacity to document and maintain individual case records.

(u)1. Parent or family peer support services shall:

a. Be emotional support that is provided by a parent or family member of a child who is experiencing a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a parent or family member with a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:230;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide parent or family peer support services, a provider

shall:

a. Have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ family peer support specialists who are qualified to provide family peer support services in accordance with 908 KAR 2:230;

c. Use a qualified mental health professional to supervise family peer support specialists;

d. Have the capacity to employ staff authorized to provide parent or family peer support in accordance with subsection (3)(u) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of parent or family peer support as stated in subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(5)(a) The following requirements shall apply to any provider of a service to a recipient for a substance use disorder or co-occurring mental health disorder and substance use disorder:

1. The licensing requirements established in 908 KAR 1:370;

2. The physical plant requirements established in 908 KAR 1:370;

3. The organization and administration requirements established in 908 KAR 1:370;

4. The personnel policy requirements established in 908 KAR 1:370;

5. The quality assurance requirements established in 908 KAR 1:370;

6. The clinical staff requirements established in 908 KAR 1:370;

7. The program operational requirements established in 908 KAR 1:370; and

8. The outpatient program requirements established in 908 KAR 1:370.

(b) The detoxification program requirements established in 908 KAR 1:370 shall apply to a provider of a detoxification service.

(6) The extent and type of assessment performed at the time of a screening shall depend upon the problem of the individual seeking or being referred for services.

(7) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(8)(a) Direct contact between a provider or practitioner and a recipient shall be required for each service except for a collateral service for a child under the age of twenty-one (21) years if the collateral service is in the child's plan of care.

(b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(9) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter.

(10) A service shall be:

(a) Stated in a recipient's treatment plan;

(b) Provided in accordance with a recipient's treatment plan;

(c) Provided on a regularly scheduled basis except for a screening or assessment; and

(d) Made available on a nonscheduled basis if necessary during a crisis or time of increased stress for the recipient.

(11) The following services or activities shall not be covered under this administrative regulation:

(a) A behavioral health service provided to:

1. A resident of:

a. A nursing facility; or

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

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;

(c) A consultation or educational service provided to a recipient or to others;

(d) Collateral outpatient therapy for an individual aged twenty-one (21) years or older;

(e) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;

(f) Travel time;

(g) A field trip;

(h) A recreational activity;

(i) A social activity; or

(j) A physical exercise activity group.

(12)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as specified in Section 2(2)(k).

(b) A third party contract shall not be covered under this administrative regulation.

Section 6. Drugs for Specified Immunizations. The Cabinet for Health and Family Services shall provide free, upon request, drugs necessary for the following immunizations:

(1) Diphtheria and tetanus toxoids and pertussis vaccine (DPT);

(2) Measles, mumps, and rubella virus vaccine live (MMR);

(3) Poliovirus vaccine, live, oral, any type (OPV); or

(4) Hemophilus B conjugate vaccine (HBCV).

Section 7.[5.] Coverage Limits. (1)(a) Except as established in subsection (2) of this section, pharmacy service coverage shall be limited to drugs covered pursuant to 907 KAR 1:019.

(b) A drug or biological not covered through the department's pharmacy program shall be covered if necessary for treatment of an emergency condition.

(2) Laboratory service coverage shall be limited to:

(a) Services provided directly by a PCC, an FQHC, or an FQHC look-alike; or

(b) If purchased, other laboratory services covered pursuant to 907 KAR 1:028.

(3) Dental service coverage shall be limited to dental service coverage pursuant to 907 KAR 1:026.

(4) Vision service coverage shall be limited to vision service coverage pursuant to 907 KAR 1:038.

(5) Audiology service coverage shall be limited to hearing service coverage pursuant to 907 KAR 1:038.

(6) An abortion or sterilization service shall be:

(a) Allowed in accordance with:

1. 42 C.F.R.441, Subpart E or Subpart F; and

2. KRS 205.010(3), 205.510(5), and 212.275(3); and

(b) Covered within the scope and limitations of federal law, federal regulations, and state law.

(7) Durable medical good and prosthetic coverage shall be limited to durable medical good or prosthetic coverage pursuant to 907 KAR 1:479 or 907 KAR 1:030.

(8) A holding or observation accommodation shall be covered:

(a) For no more than twenty-four (24) hours; and

(b) If:

1. The recipient's medical record:

a. Documents the appropriateness of the holding or observation accommodation; and

b. Contains a statement of conditions observed and treatment rendered during the holding time;

2. A physician:

a. Determines that the holding or observation accommodation is necessary; and

b. Is on call at all times when a recipient is held beyond the regularly scheduled hours of the center; and

3. A licensed nurse is on duty during the time the recipient patient remains beyond regularly-scheduled hours.

(9) A radiology procedure shall be covered if provided by a licensed practitioner of the healing arts or by an individual holding a valid certificate to operate sources of radiation.

Section 8.[6-] Noncovered Services. (1) The following services shall not be covered as PCC,[e] FQHC, or FQHC look-alike services:

(a)[(4)] Services provided in a hospital as defined in 42 U.S.C. 1395x(e);

(b)[(2)] Institutional services;

(c)[(3)] Housekeeping, babysitting, or other similar homemaker services;[e]

(d)[(4)] Services which are not provided in accordance with restrictions imposed by law or administrative regulation;

(e) A behavioral health service provided to:

1. A resident of:

a. A nursing facility; or

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

2. An inmate of a federal, local, or state:

a. Jail;

b. Detention center; or

c. Prison; or

3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;

(f) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;

(g) A consultation or educational service provided to a recipient or to others;

(h) Collateral outpatient therapy for an individual aged twenty-one (21) years or older;

(i) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;

(j) Travel time;

(k) A field trip;

(l) A recreational activity;

(m) A social activity; or

(n) A physical exercise activity group.

(2)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as specified in Section 2(2)(k).

(b) A third party contract shall not be covered under this administrative regulation.

Section 9. Medical Necessity Requirement. To be covered pursuant to this administrative regulation, a service shall be:

(1) Medically necessary for the recipient; and

(2) Provided to a recipient.

Section 10. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a service from an independent mental health service provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a primary care center.

Section 11. Protection, Security and Records Maintenance Requirements for All Services. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the

service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3)(a) A provider shall comply with 45 C.F.R. Part 164.

(b) All information contained in a health record shall:

1. Be treated as confidential;

2. Not be disclosed to an unauthorized individual; and

3. If requested, be disclosed to an authorized representative of:

a. The department; or

b. Federal government.

(c)1. Upon request, a provider shall provide to an authorized representative of the department or federal government information requested to substantiate:

a. Staff notes detailing a service that was rendered;

b. The professional who rendered a service;

c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department.

2. Failure to provide information referenced in subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 12. Documentation and Records Maintenance Requirements for Behavioral Health Services. (1) The requirements in this section shall apply to health records associated with behavioral health services.

(2) A health record shall:

(a) Include:

1. An identification and intake record including:

a. Name;

b. Social Security number;

c. Date of intake;

d. Home (legal) address;

e. Health insurance information;

f. Referral source and address of referral source;

g. Primary care physician and address;

h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider; and

k. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

(i) This administrative regulation;

(ii) The provider's licensure board;

(iii) State law; or

(iv) Federal law;

2. Documentation of the:

a. Screening;

b. Assessment;

c. Disposition; and

d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;

3. A complete history including mental status and previous treatment:

4. An identification sheet;

5. A consent for treatment sheet that is accurately signed and dated; and

6. The individual's stated purpose for seeking services; and

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the Cabinet for Health and Family Services upon request;

3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;

4. Readily accessible; and

5. Adequate for the purpose establishing the current treatment modality and progress of the recipient.

(3) Documentation of a screening shall include:

(a) Information relative to the individual's stated request for services; and

(b) Other stated personal or health concerns if other concerns are stated.

(4)(a) A provider's notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit;

2. Describe the:

a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

b. Therapist's intervention;

c. Changes in the treatment plan if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional providing the service.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(5) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) An appropriate diagnosis;

(b) A referral for further consultation and disposition, if applicable; and

(c)1. Termination of services and referral to an outside source for further services; or

2. Termination of services without a referral to further services.

(6)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.

(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.

(7)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Be dated;

3. Be titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(8) A termination summary shall:

(a) Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

(b) Contain a summary of the significant findings and events during the course of treatment including the:

1. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

2. Final diagnosis of clinical impression; and

3. Individual's condition upon termination and disposition.

(c) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(9) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(10) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient.

(11)(a) If a provider's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records of the provider shall:

1. Remain the property of the provider; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A provider shall have a written plan addressing how to maintain health records in the event of the provider's death.

Section 13. Medicaid Program Participation Requirements.

(1)(a) A participating FQHC, FQHC look-alike, or PCC shall be currently:

1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

2. Except as established in paragraph (c) of this subsection, participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671.

(b) A satellite facility of an FQHC, an FQHC look-alike, or a PCC shall:

1. Be currently listed on the parent facility's license in accordance with 902 KAR 20:058;

2. Comply with the requirements regarding extensions established in 902 KAR 20:058; and

3. Comply with 907 KAR 1:671.

(c) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) To be initially enrolled with the department, an FQHC or FQHC look-alike shall:

1. Enroll in accordance with 907 KAR 1:672; and

2. Submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC or FQHC look-alike.

(b) To remain enrolled and participating in the Kentucky Medicaid Program, an FQHC or FQHC look-alike shall:

1. Comply with the enrollment requirements established in 907 KAR 1:672;

2. Comply with the participation requirements established in 907 KAR 1:671; and

3. Annually submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an FQHC or FQHC look-alike to the department.

(c) The requirements established in paragraphs (a) and (b) of this subsection shall apply to a satellite facility of an FQHC or FQHC look-alike.

(3) An FQHC, an FQHC look-alike, or a PCC that operates multiple satellite facilities shall:

(a) List each satellite facility on the parent facility's license in accordance with 902 KAR 20:058; and

(b) Consolidate claims and cost report data of its satellite facilities with the parent facility.

(4) An FQHC, an FQHC look-alike, or a PCC that has been terminated from federal participation shall be terminated from Kentucky Medicaid Program participation.

(5)(a) A participating FQHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC.

(b) A participating FQHC look-alike and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an FQHC look-alike.

(c) A participating PCC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of a PPC.

(6) An FQHC, an FQHC look-alike, or a PCC performing laboratory services shall meet the requirements established in 907 KAR 1:028 and 907 KAR 1:575.

(7)(a) If an FQHC, an FQHC look-alike, or a PCC receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(8) An FQHC, an FQHC look-alike, or a PCC shall:

(a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability; and

(b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the act.

Section 14. Third Party Liability. A provider shall comply with KRS 205.622.

Section 15. 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 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, or 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 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 16. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 17. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 18. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program federally-qualified health center (FQHC) services, FQHC look-alike services, and primary care center (PCC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program FQHC services, FQHC look-alike services, and PCC 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 coverage provisions and requirements regarding Medicaid Program FQHC services, FQHC look-alike services, and PCC 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 authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program FQHC services, FQHC look-alike services, and PCC 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 primary amendment authorizes FQHCs, FQHC look-alikes, and PCCs to provide substance use disorder services and expands these providers scope of behavioral health services as well as expands the types of practitioners/professionals who can provide services in an FQHC, an FQHC-look-alike, or a PCC. Additional amendments include inserting various program integrity requirements such as requiring FQHCs, FQHC look-alikes, and PCCs to bill third parties for services if a third party is involved and not duplicate bill for a service provided to the recipient by another provider. Other amendments include establishing that FQHCs, FQHC look-alikes, and PCCs must comply with records maintenance/security requirements and Medicaid provider participation requirements. A new section is added to authorize FQHCs, FQHC look-alikes, and PCCs to utilize electronic signatures. Another section is added to establish that Medicaid

Program coverage of FQHC services, FQHC look-alike services, and PCC services under this administrative regulation is contingent upon federal approval and federal funding. Also, there is an amendment which clarifies that the Department for Medicaid Services has the authority to audit any provider claim, medical record, or documentation associated with any claim or medical record. Lastly, a section establishing recipient appeal rights regarding adverse actions is added.

(b) The necessity of the amendment to this administrative regulation: The primary amendment – amendment related to substance use disorder services and behavioral health services – is necessary to comply with a federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." Additionally, the Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange. The Medicaid Program is required to ensure that recipients have access to services. Other amendments are necessary to enhance program integrity requirements, establish that coverage of services is contingent upon federal funding (in order to protect state taxpayer generated funds), and establish appeal rights for Medicaid recipients.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(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 complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Federally-qualified health centers and primary care centers will be affected by this amendment. Additionally, licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide substance use disorder services or the enhanced behavioral health services (established in this amendment) while working for or under contract with an FQHC, FQHC look-alike, or PCC will also be affected by this administrative regulation. Medicaid recipients who qualify for substance use disorder services or the enhanced scope of behavioral health services will also be affected by this amendment.

(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. FQHCs, FQHC look-alikes, and PCCs will need to ensure that they use the practitioners authorized in this administrative regulation to provide the new scope of services (expanded behavioral health services and substance use disorder services) if the given FQHCs, FQHC look-alikes, or PCCs wish to expand their scope of services accordingly.

(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 anticipated as expanding the scope of services is voluntary.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). FQHCs, FQHC look-alikes, and PCCs will benefit by being authorized to provide more services. The expanded types of behavioral health practitioners/professionals will benefit by having more employment opportunities in which to provide services. Medicaid recipients will benefit by having enhanced access to behavioral health services and substance use disorder services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in FQHC, FQHC look-alikes, and PCCs due to the variables involved as DMS cannot estimate how many FQHCs, FQHC look-alikes, or PCCs will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in FQHCs, FQHC look-alikes, or PCCs.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2).

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services

required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

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 the amendment to this administrative regulation as will any FQHC, FQHC look-alike, or PCC owned by a government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many FQHCs, FQHC look-alikes, or PCCs that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in FQHC, FQHC look-alikes, and PCCs due to the variables involved as DMS cannot estimate how many FQHCs, FQHC look-alikes, or PCCs will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope

of behavioral health services in FQHCs, FQHC look-alikes, or PCCs.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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 Policy and Operations

(Amendment)

907 KAR 1:082. Coverage provisions and requirements regarding rural health clinic services.

RELATES TO: KRS 205.520, 314.011, 319.050, 335.100, 42 C.F.R. 400.203, 42 C.F.R. 405.2401(b), 405.2412-405.2417, 405.2450, 405.2452, 405.2468, 440.20, 42 C.F.R. 491.1-491.11, 42 U.S.C. 1395x(aa) and (hh)

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 Medicaid Program. KRS[Chapter] 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program coverage provisions and requirements relating to [coverage of] rural health clinic services[for which payment shall be made by the Medicaid Program on behalf of both categorically needy and medically needy].

Section 1. Definitions. (1) "Advanced practice registered nurse[practitioner]" is defined by KRS [Chapter] 314.011(7).

(2) "Certified social worker" means an individual who:

(a) Meets the requirements established in KRS 335.080; and

(b) Has at least a master's degree in social work.

(3) "Clinical psychologist" means a doctorate level psychologist who is licensed in accordance with KRS 319.050.

(4) "Club house model of psychosocial rehabilitation" means a form of psychosocial rehabilitation that focuses on self-help, friendship, emotional support, acceptance, and meaningful and gainful employment.

(5) "Community support associate" means an individual who meets the community support associate requirements established in 908 KAR 2:250.

(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.

(8) "Face-to-face" means occurring:

(a) In person; or

(b) Via a real-time, electronic communication that involves two (2) way interactive video and audio communication.

(9) "Family peer support specialist" means an individual who meets the requirements for a Kentucky family peer support specialist established in 908 KAR 2:230.

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

(11) "Fountain House" means the professional self-help program located in New York City about which information is available on the Web site of <http://www.fountainhouse.org/>.

(12)[(4)] "Homebound recipient" is defined by 42 C.F.R. 440.20(b)(4)(iv).

(13)[(5)] "Intermittent nursing care" is defined by 42 C.F.R.

405.2401(b).

(14)[(6)] "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(15) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(16) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(17) "Licensed professional counselor associate" is defined by KRS 335.500(3).

(18) "Licensed psychological associate" means an individual who:

(a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.

(19) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(20) "Licensed psychologist" means an individual who:

(a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

(21) "Managed care organization" 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.

(22) "Marriage and family therapy associate" is defined by KRS 335.300(3).

(23)[(7)] "Medically necessary" means that a covered benefit or service is necessary in accordance with [the provisions of] 907 KAR 3:130[; Section 2].

(24)[(8)] "Nurse-midwife" is defined by 42 C.F.R. 405.2401(b).

(25)[(9)] "Other ambulatory services" is defined by 42 C.F.R. 440.20(c).

(26)[(10)] "Part-time nursing care" is defined by 42 C.F.R. 405.2401(b).

(27) "Peer support specialist" means an individual who meets the peer specialist qualifications established in 908 KAR 2:220.

(28)[(11)] "Physician" is defined by KRS 205.510(11) and 42 C.F.R. 405.2401(b).

(29)[(12)] "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(30) "Qualified mental health professional" is defined by KRS 202A.011(12).

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

(32)[(13)] "Rural health clinic" or "RHC" is defined by 42 C.F.R. 405.2401(b).

(33)[(14)] "State plan" is defined by 42 C.F.R. 400.203.

(34)[(15)] "Visiting nurse services" is defined by 42 C.F.R. 405.2401(b).

(35) "Youth peer support specialist" means an individual who meets the requirements established for a Kentucky youth peer support specialist established in 908 KAR 2:240.

Section 2. Covered Services Other Than Behavioral Health Services. The department shall cover the following medically necessary rural health clinic services furnished by an RHC that has been certified in accordance with 42 C.F.R. 491.1 through 491.11:

(1) Services pursuant to 42 U.S.C. 1395x(aa);

(2) Services provided by a physician if the physician:

(a) Complies with the physician responsibility requirements established by 42 C.F.R. 491.8(b); and

(b)1. Performs the services in an RHC; or

2. Is compensated under an agreement with an RHC for providing services furnished to a Medicaid eligible RHC patient in a location other than the RHC;

(3) Services provided by a physician assistant, advanced practice registered nurse[practitioner], or nurse midwife who is employed by or receives compensation from the RHC if the services:

(a) Are furnished by a member of the RHC's staff who complies with the responsibility requirements established by 42 C.F.R. 491.8(c);

(b) Are furnished under the medical supervision of a physician;

(c) Are furnished in accordance with a medical order for the care and treatment of a patient as prepared by a physician;

(d) Are within the provider's legally-authorized scope of practice; and

(e) Would be covered if furnished by a physician;

(4) Services or supplies furnished as an incident to services provided by a physician, physician assistant, advanced practice registered nurse[practitioner], or nurse midwife if the service or supply meets the criteria established in 42 C.F.R. 405.2413 or 42 C.F.R. 405.2415;

(5) Part-time or intermittent visiting nurse care and related supplies, except for drugs or biologicals, if:

(a) The RHC is located in an area where a determination has been made that there is a shortage of home health agencies pursuant to 42 C.F.R. 405.2417;

(b) The services are provided by a registered nurse, licensed practical nurse, or a licensed vocational nurse who is employed by or compensated for the services by the RHC; and

(c) The services are furnished to a homebound recipient under a written plan of treatment that is:

1. Established and reviewed at least every sixty (60) days by a supervising physician of the RHC; or

2. Established by a physician, physician assistant, advanced practice registered nurse[practitioner], or nurse midwife and reviewed and approved at least every sixty (60) days by a supervising physician of the RHC; or

(6)[Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced practice registered nurse practitioner if the services are:

(a) Provided by an individual who is employed by or furnishes services under contract to the RHC; and

(b) Within the provider's legally-authorized scope of practice;

(7) Services or supplies incident to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in 42 C.F.R. 405.2452; and

(8) Other ambulatory services as established in the state plan.

Section 3. Behavioral Health Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for:

(a) A mental health disorder;

(b) A substance use disorder; or

(c) Co-occurring mental health and substance use disorders.

(2) The department shall cover, and a rural health clinic may provide, the following services:

(a) Behavioral health services provided by a clinical psychologist, licensed clinical social worker, or advanced practice registered nurse within the provider's legally authorized scope of service; or

(b) Services or supplies incidental to a clinical psychologist's or licensed clinical social worker's behavioral health services if the service or supply meets the criteria established in Title 42 C.F.R.

(3) In addition to the services referenced in subsection (2) of this section, the following behavioral health services provided by a rural health clinic shall be covered under this administrative regulation in accordance with the corresponding following requirements:

(a) A screening provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the

(n) Peer support provided by:

3. A youth peer support specialist working under the supervision of a mental health professional;

1. A licensed psychologist;

3. A licensed clinical social worker;

5. A physician;

7. An advanced practice registered nurse;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

15. A family peer support specialist working under the supervision of a mental health professional; or

(p) Assertive community treatment provided by a team that includes at least two (2) of the following:

2. A licensed professional clinical counselor;

4. A licensed marriage and family therapist;

6. A psychiatrist;

8. A licensed psychological practitioner;

supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

15. A family peer support specialist working under the supervision of a mental health professional; or

(g) Intensive outpatient program provided by a team that

1. A licensed psychologist;

3. A licensed clinical social worker;

5. A physician;

7. An advanced practice registered nurse:

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

1. A licensed psychologist;

3. A licensed clinical social worker;

5. A physician;

7. An advanced practice registered nurse;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

15. A family peer support specialist working under the supervision of a mental health professional; or

(s) Residential services for a substance use disorder provided by a team of at least two (2) of the following:

2. A licensed professional clinical counselor:

4. A licensed marriage and family therapist:

6. A psychiatrist

7. An advanced practice registered nurse;

8. A licensed psychological practitioner:

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the

service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(t) Therapeutic rehabilitation program services provided by a team of at least two (2) of the following individuals:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional; or

(u) Parent or family peer support provided by:

1. A peer support specialist working under the supervision of a mental health professional;

2. A family peer support specialist working under the supervision of a mental health professional; or

3. A youth peer support specialist working under the supervision of a mental health professional.

(4)(a) A screening shall:

1. Be the determination of the likelihood that an individual has a mental health disorder, a substance use disorder, or co-occurring disorders;

2. Not establish the presence or specific type of disorder; and

3. Establish the need for an in-depth assessment.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the provider to:

a. Establish the presence or absence of a mental health disorder or substance use disorder;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinic disorder or service need;

3. Include working with the individual to develop a treatment and service plan; and

4. Not include a psychological or psychiatric evaluation or assessment.

(c) Psychological testing shall include:

1. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and

2. Interpretation and a written report of testing results.

(d) Crisis intervention:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:

a. The recipient; or

b. Another individual;

2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for an individual with a behavioral health disorder;

3. Shall be provided:

a. In an office, home, or community setting where the individual is experiencing the crisis;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one-on-one encounter between the provider and the recipient;

4. May include verbal de-escalation, risk assessment, or cognitive therapy; and

5. Shall be followed by a referral to non-crisis services if applicable.

(e)1. Service planning shall consist of assisting a recipient in creating an individualized plan for services needed to maintain functional stability or return to stability as soon as possible in order to avoid out-of-home care.

2. A service plan;

a. Shall be directed by the recipient; and

b. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

(f) Individual outpatient therapy shall:

1. Be provided to promote the:

a. Health and wellbeing of the individual; or

b. Recovery from a substance related disorder;

2. Consist of:

a. A face-to-face, one-on-one encounter between the provider and recipient; and

b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

a. Reducing adverse symptoms;

b. Reducing or eliminating the presenting problem of the recipient; and

c. Improving functioning; and

4. Not exceed three (3) hours per day.

(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals, including multiple members from one (1) family, who participate in the session.

(h)1. Group outpatient therapy shall:

a. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Recovery from a substance related disorder;

b. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

c. Be provided to a recipient in a group setting:
 (i) Of nonrelated individuals; and
 (ii) Not to exceed eight (8) individuals in size;
 d. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;
 e. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and
 f. Not exceed three (3) hours per day.
 2. The group shall have a:
 a. Deliberate focus; and
 b. Defined course of treatment.
 3. The subject of a group receiving group outpatient therapy shall be related to each recipient participating in the group.
 4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.
 (i) 1. Collateral outpatient therapy shall:
 a. Consist of a face-to-face behavioral health consultation:
 (i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and
 (ii) That is provided in accordance with the recipient's treatment plan; and
 b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age.
 2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.
 (j) Screening, brief intervention, and referral to treatment for a substance use disorder shall:
 1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and
 2. Consist of:
 a. Using a standardized screening tool to assess an individual for risky substance use behavior;
 b. Engaging a recipient who demonstrates risky substance use behavior in a short conversation and providing feedback and advice; and
 c. Referring a recipient to:
 (i) Therapy; or
 (ii) Other additional services to address substance use if the recipient is determined to need other additional services.
 (k) Medication assisted treatment for a substance use disorder:
 1. Shall include:
 a. Any opioid addiction treatment that includes a United States Food and Drug Administration-approved medication for the detoxification or maintenance treatment of opioid addiction along with counseling or other supports;
 b. Comprehensive maintenance;
 c. Medical maintenance;
 d. Interim maintenance;
 e. Detoxification; or
 f. Medically supervised withdrawal;
 2. May be provided in:
 a. An opioid treatment program;
 b. A medication unit affiliated with an opioid treatment program;
 c. A physician's office; or
 d. Other community setting; and
 3. Shall increase the likelihood for cessation of illicit opioid use or prescription opioid abuse.
 (l) 1. Day treatment shall be a nonresidential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:
 a. An emotional disability or neurobiological or substance use disorder; and
 b. A high risk of out-of-home placement due to a behavioral health issue.
 2. Day treatment services shall:
 a. Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder,

mental health, or co-occurring mental health and substance use disorders);
 b. Have unified policies and procedures that:
 (i) Address the program philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning; and
 (ii) Have been approved by the recipient's local education authority and the day treatment provider;
 c. Include:
 (i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;
 (ii) Behavior management and social skill training;
 (iii) Independent living skills that correlate to the age and development stage of the recipient; or
 (iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and
 d. Be provided:
 (i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);
 (ii) On school days and during scheduled breaks;
 (iii) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;
 (iv) Under the supervision of a licensed or certified behavioral health practitioner or a behavioral health practitioner working under clinical supervision; and
 (v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.
 3. To provide day treatment services, an RHC shall have:
 a. The capacity to employ staff authorized to provide day treatment services in accordance with subsection (3)(l) of this section and to coordinate the provision of services among team members;
 b. The capacity to provide the full range of residential crisis stabilization services as stated in subparagraph 1 of this paragraph;
 c. Demonstrated experience in serving individuals with behavioral health disorders;
 d. The administrative capacity to ensure quality of services;
 e. A financial management system that provides documentation of services and costs;
 f. The capacity to document and maintain individual case records; and
 g. Knowledge of substance use disorders.
 4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.
 (m) 1. Comprehensive community support services shall:
 a. Be activities necessary to allow an individual to live with maximum independence in community-integrated housing;
 b. Be intended to ensure successful community living through the utilization of skills training, cueing, or supervision as identified in the recipient's treatment plan;
 c. Include:
 (i) Reminding a recipient to take medications and monitoring symptoms and side effects of medications; or
 (ii) Teaching parenting skills, teaching community resource access and utilization, teaching emotional regulation skills, teaching crisis coping skills, teaching how to shop, teaching about transportation, teaching financial management, or developing and enhancing interpersonal skills; and
 d. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.
 2. To provide comprehensive community support services, an RHC shall have:
 a. The capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (3)(m) of this section and to coordinate the provision of services among team members;
 b. The capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this

paragraph:

c. Demonstrated experience in serving individuals with behavioral health disorders;

d. The administrative capacity to ensure quality of services;

e. A financial management system that provides documentation of services and costs; and

f. The capacity to document and maintain individual case records.

(n)1. Peer support services shall:

a. Be social and emotional support that is provided by an individual who is experiencing a mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders to a recipient by sharing a similar mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified consumer or parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health and substance use disorders services who has been trained and certified in accordance with 908 KAR 2:220;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide peer support services, an RHC shall:

a. Have demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220;

c. Use a qualified mental health professional to supervise peer support specialists;

d. Have the capacity to employ staff authorized to provide peer support in accordance with subsection (3)(n) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(o)1. Mobile crisis services shall:

a. Be available twenty-four (24) hours a day, seven (7) days a week, every day of the year; and

b. Be a crisis response in a home or community setting to provide an immediate evaluation, triage, and access to acute substance use disorder services including treatment and supports to:

(i) Reduce symptoms or harm; or

(ii) Safely transition an individual in an acute crisis to appropriate crisis stabilization and detoxification supports or services.

2. To provide mobile crisis services, an RHC shall have:

a. The capacity to employ staff authorized to provide mobile crisis services in accordance with subsection (3)(o) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;

c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;

d. Demonstrated experience in serving individuals with behavioral health disorders;

e. The administrative capacity to ensure quality of services;

f. A financial management system that provides documentation of services and costs;

g. The capacity to document and maintain individual case records; and

h. Knowledge of substance use disorders.

(p)1. Assertive community treatment shall:

a. Be an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for individuals with a serious mental illness;

b. Use a multidisciplinary team of at least two (2) of the following professionals:

(i) A psychiatrist;

(ii) A nurse;

(iii) A case manager; or

(iv) A therapist; and

c. Include:

(i) Assessment;

(ii) Treatment planning;

(iii) Case management;

(iv) Psychiatric services;

(v) Medication management administration;

(vi) Individual outpatient therapy;

(vii) Family outpatient therapy;

(viii) Group outpatient therapy;

(ix) Mobile crisis intervention;

(x) Mental health consultation; or

(xi) Family support and basic living skills.

2. To provide assertive community treatment services, an RHC shall:

a. Employ one (1) or more teams:

(i) Led by a qualified mental health professional; and

(ii) Comprised of at least four (4) full-time equivalents including a prescriber, a nurse, a qualified mental health professional, a case manager, or a co-occurring disorders specialist;

b. Have adequate staffing to ensure that no caseload size exceeds ten (10) participants per team member;

c. Have the capacity to employ staff authorized to provide assertive community treatment services in accordance with subsection (3)(p) of this section and to coordinate the provision of services among team members;

d. The capacity to provide the full range of assertive community treatment services as stated in this paragraph;

e. Demonstrated experience in serving individuals with persistent and serious mental illness who have difficulty living independently in the community;

f. The administrative capacity to ensure quality of services;

g. A financial management system that provides documentation of services and costs; and

h. The capacity to document and maintain individual case records.

(q)1. Intensive outpatient program services shall:

a. Be an alternative to inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;

b. Offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual outpatient therapy, group outpatient therapy, or family outpatient therapy; and

c. Be provided at least three (3) hours per day at least three (3) days per week; and

d. Include:

(i) Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless contraindicated;

(ii) Crisis intervention; or

(iii) Psycho-education.

2. During psycho-education, the recipient or family member shall be:

a. Provided with knowledge regarding the recipient's diagnosis, the causes of the condition, and the reasons why a particular treatment might be effective for reducing symptoms; and

b. Taught how to cope with the recipient's diagnosis or

condition in a successful manner.

3. An intensive outpatient program treatment plan shall:

a. Be individualized; and

b. Focus on stabilization and transition to a lesser level of care.

4. To provide intensive outpatient program services, an RHC shall have:

a. Access to a board-certified or board-eligible psychiatrist for consultation;

b. Access to a psychiatrist, other physician, or advanced practiced registered nurse for medication management;

c. Adequate staffing to ensure a minimum recipient-to-staff ratio of four (4) recipients to one (1) staff;

d. The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;

e. The capacity to employ staff authorized to provide intensive outpatient program services in accordance with subsection (3)(q) of this section and to coordinate the provision of services among team members;

f. The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;

g. Demonstrated experience in serving individuals with behavioral health disorders;

h. The administrative capacity to ensure quality of services;

i. A financial management system that provides documentation of services and costs; and

j. The capacity to document and maintain individual case records.

(r)1. Residential crisis stabilization services shall be provided in a crisis stabilization unit.

2. A crisis stabilization unit shall:

a. Be a community-based, residential program that offers an array of services including:

(i) Screening;

(ii) Assessment;

(iii) Treatment planning;

(iv) Individual outpatient therapy;

(v) Family outpatient therapy;

(vi) Group outpatient therapy; and

(vii) Psychiatric services;

b. Provide services in order to:

(i) Stabilize a crisis and divert an individual from a higher level of care;

(ii) Stabilize an individual and provide treatment for acute withdrawal, if applicable; and

(iii) Re-integrate the individual into the individual's community or other appropriate setting in a timely fashion;

c. Not be part of a hospital;

d. Be used when an individual:

(i) Is experiencing a behavioral health emergency that cannot be safely accommodated within the individual's community; and

(ii) Needs overnight care that is not hospitalization;

e. Not contain more than sixteen (16) beds; and

f. Not be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

3. Residential crisis stabilization shall not include:

a. Room and board;

b. Educational services;

c. Vocational services;

d. Job training services;

e. Habilitation services;

f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

h. Recreational activities;

i. Social activities; or

j. Services required to be covered elsewhere in the state plan.

4. To provide residential crisis stabilization services, an RHC shall have:

a. The capacity to employ staff authorized to provide residential crisis stabilization services in accordance with subsection (3)(r) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in this paragraph and on a twenty-four (24) hour a day, seven (7) day a week, every day of the year basis;

c. Access to a board certified or board-eligible psychiatrist twenty-four (24) hours a day, seven (7) days a week, every day of the year;

d. Demonstrated experience in serving individuals with behavioral health disorders;

e. The administrative capacity to ensure the quality of services;

f. A financial management system that provides documentation of services and costs;

g. The capacity to document and maintain individual case records; and

h. Knowledge of substance use disorders.

(s)1. Residential services for substance use disorders shall:

a. Be provided in twenty-four (24) hour per day units;

b. Be short or long term to provide intensive treatment and skills building in a structured and supportive environment;

c. Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery;

d. Be provided in a twenty-four (24) hour a day, live-in facility that offers a planned and structured regimen of care aimed to treat individuals with addiction or co-occurring mental health and substance use disorders;

e. Assist a recipient in making necessary changes in the recipient's life to enable the recipient to live drug- or alcohol-free;

f. Last less than thirty (30) days;

g. Be provided under the medical direction of a physician;

h. Provide continuous nursing services;

i. Be based on individual need and may include:

(i) Screening;

(ii) Assessment;

(iii) Service planning;

(iv) Individual outpatient therapy;

(v) Group outpatient therapy; or

(vi) Family outpatient therapy; and

j. Be provided in accordance with 908 KAR 1:370.

2. A residential service for substance use disorder building shall have more than eight (8) but less than seventeen (17) beds.

3. A short-term length-of-stay for residential services for a substance use disorder shall:

a. Be between fourteen (14) and twenty-eight (28) days in duration;

b. Include planned clinical program activities constituting at least fifteen (15) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize and maintain a person's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.i. of this paragraph.

4. A long-term length-of-stay for residential services for a substance use disorder shall:

a. Be between twenty-eight (28) days and ninety (90) days in duration;

b. Include planned clinical program activities constituting at least forty (40) hours per week of structured professionally-directed treatment activities to:

(i) Stabilize and maintain a person's substance use disorder; and

(ii) Help the recipient develop and apply recovery skills; and

c. May include the services listed in subparagraph 1.i. of this paragraph.

5. Residential services for a substance use disorder shall not include:

a. Room and board;

b. Educational services;

c. Vocational services;

d. Job training services;

e. Habilitation services;

f. Services to an inmate in a public institution pursuant to 42 C.F.R. 435.1010;

g. Services to an individual residing in an institution for mental diseases pursuant to 42 C.F.R. 435.1010;

h. Recreational activities;

i. Social activities; or

j. Services required to be covered elsewhere in the state plan.

6. The physical structure in which residential services for a substance use disorder are provided shall not:

a. Contain more than sixteen (16) beds; and

b. Be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

7. To provide residential services for a substance use disorder, an RHC shall:

a. Have the capacity to employ staff authorized to provide residential services for a substance use disorder in accordance with subsection (3)(s) of this section and to coordinate the provision of services among team members;

b. Have the capacity to provide the full range of residential services for a substance use disorder as stated in this paragraph;

c. Have demonstrated experience in serving individuals with behavioral health disorders;

d. Have the administrative capacity to ensure quality of services;

e. Have a financial management system that provides documentation of services and costs;

f. Have the capacity to document and maintain individual case records; and

g. Be licensed as a nonmedical and nonhospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370.

(t)1. Therapeutic rehabilitation program services shall:

a. Occur at the provider's site or in the community;

b. Be provided to an adult with a severe mental illness or to a child (under the age of twenty-one (21) years) to enhance skills and offer experiential learning opportunities that are aligned with treatment goals and recovery principles;

c. Not be a residential program; and

d. Be a day program based on the Fountain House clubhouse model of psychosocial rehabilitation for individuals with a serious mental illness.

2. To provide therapeutic rehabilitation program services, an RHC shall:

a. Have the capacity to employ staff authorized to provide therapeutic rehabilitation program services in accordance with subsection (3)(t) of this section and to coordinate the provision of services among team members;

b. Have the capacity to provide the full range of therapeutic rehabilitation program services as stated in this paragraph;

c. Have demonstrated experience in serving individuals with mental health disorders;

d. Have the administrative capacity to ensure quality of services;

e. Have a financial management system that provides documentation of services and costs; and

f. Have the capacity to document and maintain individual case records.

(u)1. Parent or family peer support services shall:

a. Be emotional support that is provided by a parent or family member of a child who is experiencing a mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders to a parent or family member with a child sharing a similar mental health disorder, a substance use disorder, or co-occurring mental health and substance use disorders in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health and substance use disorders who has been trained and certified in accordance with 908 KAR 2:230;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the

recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide parent or family peer support services, a provider shall:

a. Have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ family peer support specialists who are qualified to provide family peer support services in accordance with 908 KAR 2:230;

c. Use a qualified mental health professional to supervise family peer support specialists;

d. Have the capacity to employ staff authorized to provide parent or family peer support in accordance with subsection (2)(u) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of comprehensive community support services as stated in subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(5)(a) The following requirements shall apply to any provider of a service to a recipient for a substance use disorder or co-occurring mental health and substance use disorders:

1. The licensing requirements established in 908 KAR 1:370;

2. The physical plant requirements established in 908 KAR 1:370;

3. The organization and administration requirements established in 908 KAR 1:370;

4. The personnel policy requirements established in 908 KAR 1:370;

5. The quality assurance requirements established in 908 KAR 1:370;

6. The clinical staff requirements established in 908 KAR 1:370;

7. The program operational requirements established in 908 KAR 1:370; and

8. The outpatient program requirements established in 908 KAR 1:370.

(b) The detoxification program requirements established in 908 KAR 1:370 shall apply to a provider of a detoxification service.

(6) The extent and type of assessment performed at the time of a screening shall depend upon the problem of the individual seeking or being referred for services.

(7) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(8)(a) Direct contact between a provider or practitioner and a recipient shall be required for each service except for a collateral service for a child under the age of twenty-one (21) years if the collateral service is in the child's plan of care.

(b) A service that does not meet the requirement in paragraph (a) of this subsection shall not be covered.

(9) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter.

(10) A service shall be:

(a) Stated in a recipient's treatment plan;

(b) Provided in accordance with a recipient's treatment plan;

(c) Provided on a regularly scheduled basis except for a screening or assessment; and

(d) Made available on a nonscheduled basis if necessary during a crisis or time of increased stress for the recipient.

(11) The following services or activities shall not be covered under this administrative regulation:

(a) A behavioral health service provided to:

1. A resident of:
 - a. A nursing facility; or
 - b. An intermediate care facility for individuals with an intellectual disability;
2. An inmate of a federal, local, or state:
 - a. Jail;
 - b. Detention center; or
 - c. Prison; or
3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - b. Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;
 - c. A consultation or educational service provided to a recipient or to others;
 - d. Collateral outpatient therapy for an individual aged twenty-one (21) years or older;
 - e. A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;
 - f. Travel time;
 - g. A field trip;
 - h. A recreational activity;
 - i. A social activity; or
 - j. A physical exercise activity group.
- (12)(a) A consultation by one (1) provider or professional with another shall not be covered except as specified in Section 3(4)(i) of this administrative regulation.
- (b) A third party contract shall not be covered under this administrative regulation.

Section 5. Provision of Services. An RHC shall comply with the service provision requirements established by 42 C.F.R. 491.9.

Section 6.[4.] Immunizations. An RHC shall provide, upon request from a recipient, the following covered immunizations:

- (1) Diphtheria and tetanus toxoids and pertussis vaccine (DPT);
- (2) Measles, mumps, and rubella virus vaccine live (MMR);
- (3) Poliovirus vaccine, live, oral (any type(s)) (OPV); or
- (4) Hemophilus B conjugate vaccine (HBCV).

Section 7. Medical Necessity Requirement. To be covered pursuant to this administrative regulation, a service shall be:

- (1) Medically necessary for the recipient; and
- (2) Provided to a recipient.

Section 8. Noncovered Services. (1) The following services shall not be covered as rural health clinic services:

- (a) Services provided in a hospital as defined in 42 U.S.C. 1395x(e);
- (b) Institutional services;
- (c) Housekeeping, babysitting, or other similar homemaker services;
- (d) Services which are not provided in accordance with restrictions imposed by law or administrative regulation;
- (e) A behavioral health service provided to:
 1. A resident of:
 - a. A nursing facility; or
 - b. An intermediate care facility for individuals with an intellectual disability;
 2. An inmate of a federal, local, or state:
 - a. Jail;
 - b. Detention center; or
 - c. Prison; or
 3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - (f) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;
 - (g) A consultation or educational service provided to a recipient

or to others:

- (h) Collateral outpatient therapy for an individual aged twenty-one (21) years or older;
- (i) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of face-to-face;
- (j) Travel time;
- (k) A field trip;
- (l) A recreational activity;
- (m) A social activity; or
- (n) A physical exercise activity group.
- (2)(a) A consultation by one (1) provider or professional with another shall not be covered except as specified in Section 2(2)(k) of this administrative regulation.
- (b) A third party contract shall not be covered under this administrative regulation.

Section 9. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a service from an independent behavioral health service provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a rural health clinic.

Section 10. Protection, Security and Records Maintenance Requirements for All Services. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3)(a) A provider shall comply with 45 C.F.R. Part 164.

(b) All information contained in a health record shall:

1. Be treated as confidential;
2. Not be disclosed to an unauthorized individual; and
3. If requested, be disclosed to an authorized representative of:
 - a. The department; or
 - b. Federal government.

(c)1. Upon request, a provider shall provide to an authorized representative of the department or federal government information requested to substantiate:

- a. Staff notes detailing a service that was rendered;
- b. The professional who rendered a service; and
- c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department.

2. Failure to provide information referenced in subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 11. Documentation and Records Maintenance Requirements for Behavioral Health Services. (1) The requirements in this section shall apply to health records associated with behavioral health services.

(2) A health record shall:

- (a) Include:
 1. An identification and intake record including:
 - a. Name;
 - b. Social Security number;
 - c. Date of intake;

d. Home (legal) address;
e. Health insurance information;
f. Referral source and address of referral source;
g. Primary care physician and address;
h. The reason the individual is seeking help including the presenting problem and diagnosis;
i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:
(i) Where the individual is receiving treatment for the physical health diagnosis; and
(ii) The physical health provider; and
k. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:
(i) This administrative regulation;
(ii) The provider's licensure board;
(iii) State law; or
(iv) Federal law;
2. Documentation of the:
a. Screening;
b. Assessment;
c. Disposition; and
d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;
3. A complete history including mental status and previous treatment;
4. An identification sheet;
5. A consent for treatment sheet that is accurately signed and dated; and
6. The individual's stated purpose for seeking services; and
(b) Be:
1. Maintained in an organized central file;
2. Furnished to the Cabinet for Health and Family Services upon request;
3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;
4. Readily accessible; and
5. Adequate for the purpose establishing the current treatment modality and progress of the recipient.
(3) Documentation of a screening shall include:
(a) Information relative to the individual's stated request for services; and
(b) Other stated personal or health concerns if other concerns are stated.
(4)(a) A provider's notes regarding a recipient shall:
1. Be made within forty-eight (48) hours of each service visit; and
2. Describe the:
a. Recipient's symptoms or behavior, reaction to treatment, and attitude;
b. Therapist's intervention;
c. Changes in the treatment plan if changes are made; and
d. Need for continued treatment if continued treatment is needed.
(b)1. Any edit to notes shall:
a. Clearly display the changes; and
b. Be initialed and dated.
2. Notes shall not be erased or illegibly marked out.
(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional providing the service.
2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:
a. Case; and
b. Supervising professional's evaluation of the services being provided to the recipient.
(5) Immediately following a screening of a recipient, the provider shall perform a disposition related to:
(a) An appropriate diagnosis;
(b) A referral for further consultation and disposition, if applicable; and

(c)1. Termination of services and referral to an outside source for further services; or
2. Termination of services without a referral to further services.
(6)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.
(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.
(7)(a) Notes regarding services to a recipient shall:
1. Be organized in chronological order;
2. Dated;
3. Titled to indicate the service rendered;
4. State a starting and ending time for the service; and
5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.
(b) Initials, typed signatures, or stamped signatures shall not be accepted.
(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other nonreimbursable contacts shall:
1. Be recorded in the notes; and
2. Not be reimbursable.
(8)(a) A termination summary shall:
1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and
2. Contain a summary of the significant findings and events during the course of treatment including the:
a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;
b. Final diagnosis of clinical impression; and
c. Individual's condition upon termination and disposition.
(b) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.
(9) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.
(10) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient.
(11)(a) If a provider's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records of the provider shall:
1. Remain the property of the provider; and
2. Be subject to the retention requirements established in subsection (13) of this section.
(b) A provider shall have a written plan addressing how to maintain health records in the event of the provider's death.

Section 12. Medicaid Program Participation Requirements.
(1)(a) A participating RHC shall be currently:
1. Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and
2. Except as established in paragraph (b) of this subsection, participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671.
(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.
(2)(a) To be initially enrolled with the department, an RHC shall:
1. Enroll in accordance with 907 KAR 1:672; and
2. Submit proof of its certification by the United States Department of Health and Human Services, Health Resources and

Services Administration as an RHC.

(b) To remain enrolled and participating in the Kentucky Medicaid Program, an RHC shall:

1. Comply with the enrollment requirements established in 907 KAR 1:672;

2. Comply with the participation requirements established in 907 KAR 1:671; and

3. Annually submit proof of its certification by the United States Department of Health and Human Services, Health Resources and Services Administration as an RHC to the department.

(3) An RHC that has been terminated from federal participation shall be terminated from Kentucky Medicaid Program participation.

(4) A participating RHC and its staff shall comply with all applicable federal laws and regulations, state laws and administrative regulations, and local laws and regulations regarding the administration and operation of an RHC.

(5)(a) If an RHC receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 13. Third Party Liability. A provider shall comply with KRS 205.622.

Section 14. 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 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, or 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 15. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 16. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 17. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in

accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program rural health clinic (RHC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program RHC 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 coverage provisions and requirements regarding Medicaid Program RHC 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 authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program RHC 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 primary amendment authorizes rural health clinics to provide substance use disorder services and expands these providers' scope of behavioral health services as well as expands the types of practitioners/professionals who can provide behavioral health services in a rural health clinic. Additional amendments include inserting various program integrity requirements such as requiring RHCs to bill third parties for services if a third party is involved and not duplicate bill for a service provided to the recipient by another provider. Other amendments include establishing that RHCs must comply with records maintenance/security requirements and Medicaid provider participation requirements. A new section is added to authorize RHCs to utilize electronic signatures. Another section is added to establish that the coverage provisions and requirements in this administrative regulation are contingent upon federal approval and federal funding. Another new section clarifies that The Department for Medicaid Services (DMS) can audit any claim or medical record or documentation associated with any claim or medical record. Lastly, a section establishing recipient appeal rights regarding an adverse action is added.

(b) The necessity of the amendment to this administrative

regulation: The primary amendment – amendment related to substance use disorder services and mental health services – is necessary to comply with a federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." Additionally, the Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange. The Medicaid Program is required to ensure that recipients have access to services. Other amendments are necessary to enhance program integrity requirements, establish that provisions and requirements are contingent upon federal funding (in order to protect state taxpayer generated funds), and establish appeal rights for Medicaid recipients.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(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 complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Rural health clinics will be affected by this amendment. Additionally, licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide substance use disorder services or the enhanced behavioral health services (established in this amendment) while working for or under contract with an RHC will also be affected by this administrative regulation. Medicaid recipients who qualify for substance use disorder services or the enhanced scope of behavioral health services will be affected by this amendment.

(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. RHCs will need to ensure that they use the practitioners authorized in this administrative regulation to provide the new scope of services (expanded behavioral health services and substance use disorder services) if the given RHC wishes to expand its scope of services accordingly.

(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 anticipated as expanding the scope of services is voluntary.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). RHCs will benefit by being authorized to provide more services. The expanded types of behavioral health practitioners/professionals will benefit by having more employment opportunities in which to provide services. Medicaid recipients will benefit by having enhanced access to behavioral health services including substance use disorder services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in rural health clinics due to the variables involved as DMS cannot estimate how many rural health clinics will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in rural health clinics.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2)

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are

available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

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 the amendment to this administrative regulation as will any RHC owned by a local government agency.

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 Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many rural health clinics that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(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 response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in rural health clinics due to the variables involved as DMS cannot estimate how many rural health clinics will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in rural health clinics.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Commissioner's Office (Amendment)

907 KAR 1:604. Recipient cost-sharing.

RELATES TO: KRS 205.560, 205.6312, 205.6485, 205.8451, 319A.010, 327.010, 334A.020, 42 C.F.R. 430.10, 431.51, 447.15, 447.21, 447.50, 447.52, 447.53, 447.54, 447.59, 457.224, 457.310, 457.505, 457.510, 457.515, 457.520, 457.530, 457.535, 457.570, 42 U.S.C. 1396a, 1396b, 1396c, 1396d, 1396o, 1396r-6, 1396r-8, 1396u-1, 1397aa-1397jj

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.50-447.82[447.51, 447.53, 447.54, 447.55, 447.57], 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)

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[for the provision of medical assistance to Kentucky's indigent citizenry]. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments[or other similar charges] for Medicaid recipients.[KRS 205.6485(1)(e) requires the cabinet to establish, by administrative regulation, premiums for families with children in the Kentucky Children's Health Insurance Program. 42 U.S.C. 1396r-6(b)(5) allows for a monthly premium in the second six (6) months of transitional medical assistance.] This administrative regulation establishes the provisions relating to Medicaid Program[imposing and collecting] copayments[. coinsurance and premiums from certain recipients].

Section 1. Definitions. (1) ["Coinsurance" means a percentage of the cost of a Medicaid benefit that a recipient is required to pay.

(2) "Comprehensive choices" means a benefit plan for an individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022;

2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or

4. The Model Waiver II Program in accordance with 907 KAR 1:595; and

(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

(3) "Copayment" means a dollar amount representing the portion of the cost of a Medicaid benefit that a recipient is required to pay.

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

(3) "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.

(4) [(5)] "Drug" means a covered drug provided in accordance with 907 KAR 1:019 for which the Department for Medicaid Services provides reimbursement.

(5) "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

(6) ["Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to

1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;

2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of Title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C.

1396a(l)(1)(C);

5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

6. 42 C.F.R. 457.310; and

(b) Has a designated package code of 2, 3, 4, or 5.

(7) "Federal Poverty Level" or "FPL" means guidelines that are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

(7)(9) "Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive K-TAP benefits and are deprived due to death, incapacity, or absence;

2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or

3. Do not receive K-TAP benefits and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. Receive SSP benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI benefits and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or

2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(h) Pregnant women; or

(i) Medicaid works individuals.

(9) "KCHIP" means the Kentucky Children's Health Insurance Program.

(10)(10) "KCHIP - Separate Program" means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(9) "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.

(10)(11) "K-TAP" means Kentucky's version of the federal block grant program of Temporary Assistance for Needy Families (TANF), a money payment program for children who are deprived of parental support or care due to:

(a) Death;

(b) Continued voluntary or involuntary absence;

(c) Physical or mental incapacity of one (1) parent or stepparent if two (2) parents are in the home; or

(d) Unemployment of one (1) parent if both parents are in the home.

(12) "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 supplemental security income;

(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 20:020; and

(e) Meets the resource standards established in 907 KAR 20:025.

(11)(13) "Nonemergency" means a condition which does not require an emergency service pursuant to 42 C.F.R. 447.53.

(12)(14) "Nonpreferred brand name drug" means a brand name drug that is not on the department's preferred drug list.

(13)(15) "Optimum choices" means a benefit plan for an individual who:

(a) Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. An intermediate care facility for individuals with an intellectual disability in accordance with 907 KAR 1:022; or

2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and

(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.

(16) "Preferred brand name[brand-name] drug" means a brand name[brand-name] drug:

(a) For which no generic equivalent exists which has a more favorable cost to the department; and

(b) Which prescribers are encouraged to prescribe, if medically appropriate.

(14) "Preventive service" means:

(a) For a child:

1. An immunization recommended by the Centers for Disease Control; or

2. A preventive service:

a. Rated grade A or B by the United States Preventive Services Task Force (USPSTF); and

b. Recommended for children and adolescents by the USPSTF; or

(b) For an adult, a preventive service:

1. Rated grade A or B by the United States Preventive Services Task Force (USPSTF); and

2. Recommended for adults by the USPSTF.

(15)(17) "Premium" means an amount paid periodically to purchase health care benefits.

(18) "Recipient" is defined in KRS 205.8451 and applies to an individual who has been determined eligible to receive benefits under the state's Title XIX or Title XXI program in accordance with Title 907 KAR[907 KAR Chapters 1 through 4].

(16)(19) "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits[for up to twelve (12) months for families who lose Medicaid eligibility solely because of increased earnings or hours of employment of the caretaker relative or loss of earning disregards] in accordance with 907 KAR 20:005, Section 5(5).

Section 2.[Comprehensive—Choices] Copayments[and Coinsurance]. (1) The following table establishes the:

(a) Copayment amounts that a recipient shall pay, unless the recipient is exempt from cost sharing pursuant to Section 3(1) of this administrative regulation; and

(b)[Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the comprehensive choices plan shall pay the copayment or coinsurance amount established in this table, with the] Corresponding provider reimbursement deductions.

Benefit	Copayment[or Coinsurance] Amount	Amount of Copayment[or Coinsurance] Deducted from Provider
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		Reimbursement
Acute inpatient hospital admission	\$50 [\$10] copayment	Full amount of the copayment
Outpatient hospital or ambulatory surgical center visit	\$4 [\$3] copayment	Full amount of the copayment
Generic prescription drug[for an atypical anti-psychotic drug if no generic equivalent for the atypical anti-psychotic drug exists for a recipient who does not have Medicare Part D drug coverage]	\$1 copayment	Full amount of the copayment
Preferred brand name drug[for a recipient who does not have Medicare Part D drug coverage]	\$4 [\$2] copayment	Full amount of the copayment
Nonpreferred brand name drug[for a recipient who does not have Medicare Part D drug coverage]	\$8 [5% coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription]	Full amount of the copayment [coinsurance, not to exceed \$20 per nonpreferred brand name drug prescription]
Emergency room for a nonemergency visit	\$8 [5% coinsurance, up to a maximum of \$6]	Full amount of the copayment[No deduction]
DMEPOS	\$4 [3% coinsurance up to a maximum of \$15 per item]	Full[The] amount of the copayment [coinsurance or, if applicable, \$15]
Podiatry office visit	\$3 [\$2] copayment	Full amount of the copayment
Chiropractic office visit	\$3	Full amount of the copayment
Dental office visit	\$3	Full amount of the copayment
Optometry office visit	\$3	Full amount of the copayment
General ophthalmological office visit	\$3	Full amount of the copayment
Physician office visit	\$3	Full amount of the copayment
Office visit for care by a physician assistant, an advanced practice registered nurse, a certified pediatric and family nurse practitioner, or a nurse midwife	\$3	Full amount of the copayment
Office visit for care by a behavioral health professional	\$3	Full amount of the copayment
Office visit to a rural health clinic	\$3	Full amount of the copayment
Office visit to a federally qualified health center	\$3	Full amount of the copayment
Office visit to a	\$3	Full amount of the

primary care center		copayment
Physical therapy office visit	\$3	Full amount of the copayment
Occupational therapy office visit	\$3	Full amount of the copayment
Speech therapy office visit	\$3	Full amount of the copayment
Laboratory, diagnostic, or radiological service	\$3	Full amount of the copayment

(2)[A recipient shall not be liable for more than:

(a) \$225 per calendar year for prescription drug copayments or coinsurance; or

(b) \$225 per calendar year for service copayments or coinsurance.

(3)] The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.[(4) If a service or benefit is not listed in the comprehensive choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that service or benefit for an individual in the comprehensive choices benefit plan.]

Section 3. [Family Choices Copayments and Coinsurance. (1)(a) Except for an individual excluded in accordance with Section 6(1) of this administrative regulation, only KCHIP children shall be family choices individuals subject to copayments or coinsurance.

(b) An individual referenced in paragraph (a) of this subsection shall pay the copayment or coinsurance amounts established in the following table, along with the corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance Amount	Amount of Copayment or Coinsurance Deducted from Provider Reimbursement
Allergy service or testing (no copayment exists for injections)	\$2 copayment	Full amount of copayment
Generic prescription drug or atypical anti-psychotic drug if no generic equivalent exists	\$1 copayment	Full amount of copayment
Preferred brand name drug	\$2 copayment	Full amount of copayment
Nonpreferred brand name drug	\$3 copayment	Full amount of the copayment
Emergency room for a nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction

(2) A recipient shall not be liable for more than:

(a) \$225 per calendar year for prescription drug copayments or coinsurance; or

(b) \$225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

(4) If a service or benefit is not listed in the family choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that service or benefit for an individual in the family choices benefit plan.

Section 4. Global Choices Copayments and Coinsurance. (1) Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the global choices plan shall pay the copayment or coinsurance amount established in this table, with the corresponding provider reimbursement deductions:

Benefit	Copayment or Coinsurance	Copayment or Coinsurance Amount
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		Deducted _____ from Provider Reimbursement
Acute _____ inpatient hospital admission	\$50 copayment	Full _____ amount _____ of copayment
Outpatient _____ hospital or _____ ambulatory surgical center visit	\$3 copayment	Full _____ amount _____ of copayment
Laboratory, _____ or diagnostic _____ or radiology service	\$3 copayment	Full _____ amount _____ of copayment
Physician services	\$2 copayment	No deduction
Visit to a rural health clinic, a primary care center, or a federally qualified _____ health center	\$2 copayment	Full _____ amount _____ of copayment
Dental office visit	\$2 copayment	No deduction
Physical therapy	\$2 copayment	Full amount of the copayment
Speech therapy	\$1 copayment	Full amount of the copayment
Chiropractic office visit	\$2 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no _____ generic equivalent for the atypical _____ anti- psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	\$1 copayment	Full amount of the copayment
Preferred _____ brand name drug for a recipient who does not have Medicare Part D drug coverage	\$2 copayment	Full amount of the copayment
Nonpreferred brand name drug for a recipient who does not have Medicare Part D drug coverage	5% coinsurance; not to exceed \$20 _____ per nonpreferred brand name drug prescription	Full amount of the coinsurance, not to exceed \$20 _____ per nonpreferred brand name _____ drug prescription
Emergency room for a _____ nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction
DMEPOS	Three _____ (3) percent coinsurance not to exceed \$15 per item	The amount of the coinsurance _____ or, _____ if applicable, \$15
Podiatry office visit	\$2 copayment	Full amount of the copayment
Ophthalmological or optometric office visit (99000 _____ series evaluation _____ and management codes)	\$2 copayment	Full amount of the copayment

(2) Physician services shall:

- (a) Include care provided by a physician, a certified pediatric and family nurse practitioner, a nurse midwife, an advanced registered nurse practitioner, or a physician assistant; and
- (b) Not include a visit to a federally-qualified health center, rural health clinic, or a primary care center.

(3) A recipient shall not be liable for more than:

- (a) \$225 per calendar year for prescription drug copayments or coinsurance; or
- (b) \$225 per calendar year for service copayments or coinsurance.

(4) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

(5) If a service or benefit is not listed in the global choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that service for an individual in the global choices benefit plan.

Section 5. Optimum Choices Copayments and Coinsurance.

(1) Except for an individual excluded pursuant to Section 6(1) of this administrative regulation, a recipient of the optimum choices plan shall pay the copayment or coinsurance amount established in this table, with the corresponding provider reimbursement deductions.

Benefit	Copayment or Coinsurance Amount	Amount _____ of Copayment _____ or Coinsurance Deducted _____ from Provider Reimbursement
Acute _____ inpatient hospital admission	\$10 copayment	Full amount of the copayment
Outpatient _____ hospital or _____ ambulatory surgical center visit	\$3 copayment	Full amount of the copayment
Generic prescription drug or an atypical anti-psychotic drug if no _____ generic equivalent for the atypical _____ anti- psychotic drug exists for a recipient who does not have Medicare Part D drug coverage	\$1 copayment	Full amount of the copayment
Preferred _____ brand name drug for a recipient who does not have Medicare Part D drug coverage	\$2 copayment	Full amount of the copayment
Nonpreferred brand name drug for a recipient who does not have Medicare Part D drug coverage	5% coinsurance; not to exceed \$20 _____ per nonpreferred brand name drug prescription	Full amount of the coinsurance, not to exceed \$20 _____ per nonpreferred brand name _____ drug prescription
Emergency room for a _____ nonemergency visit	5% coinsurance, up to a maximum of \$6	No deduction
DMEPOS	3% coinsurance up to a maximum of \$15 per item	The amount of the coinsurance _____ or, _____ if applicable, \$15
Podiatry office visit	\$2 copayment	Full amount of the copayment

(2) A recipient shall not be liable for more than:

- (a) \$225 per calendar year for prescription drug copayments or coinsurance; or
- (b) \$225 per calendar year for service copayments or coinsurance.

(3) The maximum amount of cost-sharing shall not exceed five (5) percent of a family's income for a quarter.

(4) If a service or benefit is not listed in the optimum choices cost-sharing grid, the cost-sharing obligation shall be \$0 for that

service or benefit for an individual in the optimum choices benefit plan.

Section 6. Copayment[~~Coinsurance and Premium~~] General Provisions and ~~Exemptions~~[Exclusions]. (1)(a) A recipient shall not be exempt from paying the eight (8) dollar copayment for a nonpreferred brand name drug prescription.

(b) Except for the mandatory copayment referenced in paragraph (a) of this subsection, the department shall impose no cost sharing for the following:

1. [(a)] A service furnished to an individual who has reached his or her 18th birthday, but has not turned nineteen (19), and who is required to be provided medical assistance under 42 U.S.C. 1396a(a)(10)(A)(i)(I), including services furnished to an individual with respect to whom aid or assistance is made available under Title IV, Part B (42 U.S.C. 620 to 629i) to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Title IV, Part E (42 U.S.C. 670 to 679b), without regard to age;

2. [(b)] A preventive service[~~for example, well baby and well child care and immunizations~~] provided to a child under eighteen (18) years of age regardless of family income];

3. [(c)] A service furnished to a pregnant woman;

4. [(d)] A service furnished to a terminally ill individual who is receiving hospice care as defined in 42 U.S.C. 1396d(o);

5. [(e)] A service furnished to an individual who is an inpatient in a hospital, nursing facility, intermediate care facility for individuals with an intellectual disability, or other medical institution, if the individual is required, as a condition of receiving services in the institution under Kentucky's Medicaid Program, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;

6. [(f)] An emergency service as defined by 42 C.F.R. 447.53;

7. [(g)] A family planning service or supply as described in 42 U.S.C. 1396d (a)(4)(C); or

8. [(h)] A service furnished to a woman who is receiving medical assistance via the application of 42 U.S.C. 1396a(a)(10)(A)(ii)(XVIII) and 1396a(aa).

(2) The department has determined that any individual liable for a copayment[~~coinsurance amount or premium~~] shall:

(a) Be able to pay a required copayment[~~coinsurance amount or premium~~]; and

(b) Be responsible for a required copayment[~~coinsurance or premium~~].

(3) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396r-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment[~~or coinsurance amount~~] for a recipient.

(4) A parent or guardian shall be responsible for a copayment[~~coinsurance amount or premium~~] imposed on a dependent child under the age of twenty-one (21).

(5) Provisions regarding a provider's ability to deny a service or benefit based on a recipient's failure to make a required copayment [or coinsurance payment] shall be as established in:

(a) KRS 205.6312(4); and

(b) 2012 Ky. Acts ch. 144, Part I.G.3.b.(14)[2006 Ky. Acts ch. 252 and in accordance with 42 U.S.C. 1396o-1].

(6) A provider:

(a) Shall collect from a recipient the copayment[~~coinsurance amount or premium~~] as imposed by the department for a recipient in accordance with this administrative regulation;

(b) Shall not waive a copayment[~~coinsurance amount, or premium~~] obligation as imposed by the department for a recipient; and

(c) May collect a copayment[~~coinsurance amount, or premium~~] at the time a benefit is provided or at a later date.

(7) Cumulative cost sharing for[~~premium payments and~~] copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of the annual family income.

(8) In accordance with 42 C.F.R. 447.82, [A monthly premium for a family who receives benefits under 42 U.S.C. 1396r-6(b) shall

not exceed three (3) percent of:

(a) The family's average gross monthly income; or

(b) The family's average gross monthly income minus the average monthly costs of child care necessary for the employment of the caretaker relative.

(9) the department shall not increase its reimbursement to a provider to offset an uncollected copayment[~~coinsurance amount or premium~~] from a recipient.[Section 7. Premiums for KCHIP--Separate Program Recipients.

(1) A family with children participating in the KCHIP-Separate Program shall pay a premium of twenty (20) dollars per family, per month.

(2)(a) The family of a new KCHIP-Separate Program eligible shall be required to pay a premium beginning with the first full month of benefits after the month of application.

(b) Benefits shall be effective with the date of application if the premium specified in paragraph (a) of this subsection has been paid.

(3) Retroactive eligibility as described in 907 KAR 20:010, Section 1(3), shall not apply to a recipient participating in the KCHIP-Separate Program.

(4)(a) If a family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(b)1. A KCHIP-Separate Program recipient shall be eligible for reenrollment upon payment of the missed premium.

2. If twelve (12) months have elapsed since a missed premium, a KCHIP-Separate Program recipient shall not be required to pay the missed premium before reenrolling.

Section 8. Premiums for Transitional Medical Assistance Recipients. (1) A family receiving a second six (6) months of TMA, whose monthly countable earned income is greater than 100 percent of the federal poverty limit, shall pay a premium of thirty (30) dollars per family, per month.

(2) If a TMA family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the benefit month for which the premium has not been paid unless the family has established to the satisfaction of the department that good cause existed for failure to pay the premium on a timely basis. Good cause shall exist under the following circumstances:

(a) An immediate family member living in the home was institutionalized or died during the payment month;

(b) The family was victim of a natural disaster including flood, storm, earthquake, or serious fire;

(c) The caretaker relative was out of town for the payment month; or

(d) The family moved and reported the move timely, but the move resulted in:

1. A delay in receiving the billing notice; or

2. Failure to receive the billing notice.]

Section 4.9. Premiums for Medicaid Works Individuals. (1)(a) A Medicaid Works individual shall pay a monthly premium that is:

1. Based on income used to determine eligibility for the program; and

2. Established in subsection (2) of this section.

(b) The monthly premium shall be:

1. Thirty-five (35) dollars for an individual whose income is greater than 100 percent but no more than 150 percent of the FPL;

2. Forty-five (45) dollars for an individual whose income is greater than 150 percent but no more than 200 percent of the FPL; and

3. Fifty-five (55) dollars for an individual whose income is greater than 200 percent but no more than 250 percent of the FPL.

(2) An individual whose family income is equal to or below 100 percent of the FPL shall not be required to pay a monthly premium.

(3) A Medicaid Works individual shall begin paying a premium with the first full month of benefits after the month of application.

(4) Benefits shall be effective with the date of application if the premium specified in subsection (1) of this section has been paid.

(5) Retroactive eligibility pursuant to 907 KAR 20:010, Section 1(3), shall not apply to a Medicaid Works individual.

(6) If a recipient fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(7) A Medicaid Works individual shall be eligible for reenrollment upon payment of the missed premium providing all other technical eligibility, income, and resource standards continue to be met.

(8) If twelve (12) months have elapsed since a missed premium, a Medicaid Works individual shall not be required to pay the missed premium before reenrolling. ~~[Section 10. Notices and Collection of Premiums. (1) Premiums shall be collected in accordance with Sections 7, 8, and 9 of this administrative regulation.]~~

(2) The department shall give advance written notice of the:

(a) Premium amount; and

(b) Date the premium is due.

(3) ~~To continue to receive benefits, a family shall pay a premium:~~

(a) In full; and

(b) In advance.

(4) ~~If a family pays the required premiums semiannually or quarterly in advance, they shall receive a ten (10) percent discount.]~~

Section 5. ~~[11.] Provisions for Enrollees [Recipients in Medicaid-Managed Care].~~ (1) ~~A managed care organization [entity]:~~

(1)(a) ~~Shall not impose [on a recipient receiving services through a managed care entity operating in accordance with 907 KAR 1:705] a copayment on an enrollee [coinsurance or premium] that exceeds a copayment [coinsurance or premium] established in this administrative regulation; and~~

(2)(b) ~~May impose on an enrollee [upon a recipient referenced in paragraph (a) of this subsection]:~~

(a) ~~[1.] A lower copayment [coinsurance or premium] than established in this administrative regulation; or~~

(b) ~~[2.] No copayment [coinsurance or premium. (2) A six (6) month guarantee of eligibility as described in 907 KAR 1:705, Section 3(6)] shall not apply to a recipient required to pay a premium pursuant to Section 7 of this administrative regulation].~~

Section 6. ~~[12.] Freedom of Choice. (1) In accordance with 42 C.F.R. 431.51, a recipient who is not an enrollee may obtain services from any qualified provider who is willing to provide services to that particular recipient.~~

(2) ~~A managed care organization may restrict an enrollee's choice of providers to the providers in the provider network of the managed care organization in which the enrollee is enrolled except as established in:~~

(a) 42 C.F.R. 438.52; or

(b) 42 C.F.R. 438.114(c).

Section 7. ~~[13.] Notice of Discontinuance, Hearings, and Appeal Rights. (1) The department shall give written notice of, and an opportunity to pay, past due premiums prior to discontinuance of benefits for nonpayment of a premium.~~

(2)(a) ~~If a family's income has declined, the family shall submit documentation showing the decline in income.~~

(b) ~~Following receipt of the documentation, the department shall determine if the family is required to pay the premiums established in Section 7, 8, or 9 of this administrative regulation using the new income level.~~

(c) ~~If the family is required to pay the premium and the premium has not been paid, the benefits shall be discontinued in accordance with Section 7(4)(a), 8(2), or 9(6) of this administrative regulation.~~

(d) ~~If the family is not required to pay the premium, benefits shall be continued under an appropriate eligibility category.~~

(3) ~~The department shall provide the recipient with an opportunity for a hearing in accordance with 907 KAR 1:560 upon discontinuing benefits for nonpayment of premiums.~~

(4) ~~An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

Section 8. Effective Date. The cost sharing provisions and requirements established in this administrative regulation shall be effective beginning January 1, 2014.

Section 9. Federal Approval and Federal Funding. The department's copayment provisions established in this administrative regulation shall be contingent upon:

(1) The receipt of federal financial participation; and

(2) Centers for Medicare and Medicaid Services' approval.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the cost sharing requirements and provisions for the Kentucky Medicaid program.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the cost sharing requirements and provisions for the Kentucky Medicaid program.

(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 cost sharing requirements and provisions for the Kentucky Medicaid program.

(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 cost sharing requirements and provisions for the Kentucky Medicaid program.

(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 eliminates references to four (4) benefit plans to which Medicaid recipients previously have been assigned (comprehensive choices, family choices, global choices, and optimum choices) along with the corresponding cost sharing for each benefit plan; establishes uniform cost sharing for Medicaid recipients (except for those who are exempt from cost sharing or are enrolled with a managed care organization); eliminates premiums; eliminates references to co-insurance as only copayments, rather than coinsurance, are imposed going forward; establishes that the eight (8) dollar copayment for a nonpreferred brand name drug applies to all Medicaid recipients (no exemptions); establishes that the Department for Medicaid Services (DMS) will reduce the provider's reimbursement by the

amount of the copayment for a physician's office visit, dental office visit, and non-emergent emergency room visit (as DMS does with all other copayments); and inserts a definition of preventive services. DMS is repealing a related administrative regulation which establishes the four (4) benefit plans as there was little difference among the plans and the plans created an administrative burden for DMS, providers, and managed care organizations. As a result of eliminating the four (4) benefit plans there will be uniform cost sharing obligations. Cost sharing changes vary based on an individual's benefit plan but include raising the outpatient hospital/ambulatory surgical center copay from three (3) dollars to four (4) dollars, raising the preferred brand name drug copay from two (2) dollars to four (4) dollars, changing the non-preferred brand name drug copay from five (5) percent of the cost (not to exceed twenty (20) dollars to eight (8) dollars, raising the copay for non-emergent care in an emergency room from six (6) dollars to eight (8) dollars, lowering the durable medical equipment copay from no more than fifteen (15) dollars to a fixed copay of four (4) dollars, increasing the podiatry office visit copay from two (2) dollars to three (3) dollars, increasing the dental office visit copay from two (2) dollars to three (3) dollars, raising the ophthalmological and optometry office visit copays from two (2) dollars to three (3) dollars, increasing the physical therapy office visit from two (2) dollars to three (3) dollars, increasing the speech therapy office visit copay from one (1) dollar to three (3) dollars, establishing an occupational therapy office visit copay of three (3) dollars, increasing the physician's office visit copay from two (2) dollars to three (3) dollars, and increasing the rural health clinic office visit, the federally-qualified health center office visit, and primary care center office visit copays from two (2) dollars to three (3) dollars. DMS no longer imposes premiums for participation in the Kentucky Children's Health Insurance Program (KCHIP); thus, DMS is deleting the provisions regarding premiums.

(b) The necessity of the amendment to this administrative regulation: Eliminating the four (4) benefit plans (and establishing uniform cost sharing provisions) is necessary as the plans have minimal differences in cost sharing and created an administrative burden for the Department for Medicaid Services, providers, and managed care organizations. DMS is eliminating provisions regarding premiums because DMS no longer charges premiums for KCHIP participation as the biennium budget suspended such premiums. Inserting a definition of preventive services is necessary to clarify the services exempt from cost sharing as preventive services for all ages (as mandated by the Affordable Care Act and federal regulation) are exempt from cost sharing. DMS adopted the definition of preventive services that comports with the relevant federal law and regulation. DMS is increasing cost sharing amounts for services as permitted by federal requirements in order to discourage inappropriate utilization of Medicaid services. DMS is not exempting anyone from the eight (8) dollar nonpreferred brand name drug copayment because for such drugs there will always be a preferred brand name drug option and DMS wants to encourage use of preferred brand name drugs over nonpreferred brand name drugs. Reducing provider's reimbursement by the amount of the copayment for physician's office visits, dental office visits, and non-emergent emergency room visits is necessary to comply with federal regulation and directive from the Centers for Medicare and Medicaid Services (CMS). Establishing that DMS's cost sharing is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being spent in the event that federal matching funds are not provided.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by eliminating an administratively burdensome (for DMS and providers) benefit plan structure; complying with federal requirements; complying with the biennium budget; protecting Kentucky taxpayer monies in the event that federal matching funds are not provided; and by discouraging inappropriate utilization of Medicaid services.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by eliminating an administratively burdensome (for DMS and providers) benefit plan

structure; complying with federal requirements; complying with the biennium budget; protecting Kentucky taxpayer monies in the event that federal matching funds are not provided; and by discouraging inappropriate utilization of Medicaid services.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: All Medicaid recipients who are not exempt from cost sharing will be affected by the amendment as well as Medicaid providers for whose services cost sharing is applied.

(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. Providers of services for which cost sharing is imposed will be required to impose cost sharing when providing the given service and recipients are responsible for paying cost sharing.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Providers may experience administrative cost associated with updating the cost sharing amounts per service or costs resulting from a Medicaid recipient refusing to pay a copayment obligation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients who receive preventive services will benefit from the lack of cost sharing applied to the services. Providers will benefit from a uniform cost sharing structure rather than a structure comprised of four (4) benefit plans with varying cost sharing obligations.

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

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost, other than programming changes to its Medicaid Management Information System (MMIS), as a result of the amendment to this administrative regulation.

(b) On a continuing basis: The response to question (a) also applies here.

(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 matching funds from 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 will be necessary to implement the amendment.

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

(9) Tiering: Is tiering applied? Tiering is applied in that some Medicaid recipients are exempt (by federal regulation or law) from most cost sharing obligations.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(14), 42 U.S.C. 1396o, 42 C.F.R. 447.50 through 447.60, 42 C.F.R. 447.82, and 42 C.F.R. 438.108

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) authorizes the Cabinet for Health and Family Services 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."

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(14) authorizes a state's Medicaid program to impose cost sharing only as allowed by 42 U.S.C. 1396o. 42 U.S.C. 1396o establishes categories of individuals for whom a state's Medicaid program may not impose cost sharing as well as cost sharing and premium limits. 42 C.F.R. 447.50 through 447.60 also establishes limits on cost sharing (based on income of the given Medicaid eligibility group); Medicaid populations exempt from cost sharing (children, pregnant women, institutionalized individuals for example); services exempt from cost sharing (emergency services, family planning services to child-bearing age individuals); prohibition against multiple cost sharing for one (1) service; a requirement that state Medicaid programs do not increase a provider's reimbursement by the amount of cost sharing; and a requirement that managed care organizations' cost sharing must comply with the aforementioned federal regulations. 42 C.F.R. 447.82 requires a state's Medicaid program to reduce its reimbursement to a provider by the amount of any cost sharing imposed on a recipient for a given service. 42 C.F.R. 438.108 establishes that a managed care organization's cost sharing must comply with the federal cost sharing requirements for Medicaid established in 42 C.F.R. 447.50 through 42 C.F.R. 447.60.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. Federal regulations 42 C.F.R. 447.50 through 42 C.F.R. 447.60, 42 C.F.R. 447.82, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 does not expect the amendment to this administrative regulation 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? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) anticipates no additional cost, other than programming changes to its Medicaid Management Information System (MMIS), as a result of the amendment to this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) also applies here.

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 Policy and Operations (Amendment)

907 KAR 1:631.[Reimbursement of] Vision Program reimbursement provisions and requirements[services].

RELATES TO: KRS 205.520, 42 C.F.R. 440.40, 440.60, 447 Subpart B, 42 U.S.C. 1396a-d

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 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[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes Medicaid Program reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization[provisions for vision services].

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designated agent.

(2) "Enrollee" means a recipient who is enrolled with a managed care organization.

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

(4) "Healthcare common procedure coding system" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services that represent procedures or items.

(5) "Managed care organization" 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.

(6) "Global Insight Index" means an indication of changes in health care costs from year to year developed by Global Insight.

(3) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(7)[(4)] "Ophthalmic dispenser" means an individual who is qualified to engage in the practice of ophthalmic dispensing in accordance with KRS 326.030 or 326.040.

(8) "Optometrist" is defined by KRS 311.271.

(9) "Provider" is defined by KRS 205.8451(7).

(10) "Recipient" is defined by KRS 205.8541(9)[a physician, optician, or optometrist, who is licensed to prepare and dispense lenses and eyeglasses in accordance with an original, written prescription.

(5) "Resource-based relative value scale unit" or "RBRVS unit" means a value based on the service which takes into consideration the practitioners' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price].

Section 2. General Requirements. (1)(a) For the department to reimburse for a vision service or item, the service or item shall be:

1. Provided:

a. To a recipient; and

b. By a provider who:

(i) Is enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Except as established in paragraph (b) of this subsection, is currently participating in the Medicaid Program pursuant to 907

KAR 1:671; and

(iii) Is authorized by this administrative regulation to provide the given service or item:

2. Covered in accordance with 907 KAR 1:632;

3. Medically necessary;

4. A service or item authorized within the scope of the provider's licensure; and

5. A service or item listed on the Department for Medicaid Services Vision Program Fee Schedule.

(b) In accordance with 907 KAR 17:010, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) To be recognized as an authorized provider of vision services, an optometrist shall:

1. Be certified by the:

a. Kentucky Board of Optometric Examiners; or

b. Optometric examiner board of the state in which the optometrist practices if the optometrist practices in a state other than Kentucky;

2. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

3. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(b)1. To be recognized as an authorized provider of vision services, an in-state optician shall:

a. Hold a current license in Kentucky as an ophthalmic dispenser;

b. Comply with the requirements established in KRS Chapter 326;

c. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

d. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

2. To be recognized as an authorized provider of vision services, an out-of-state optician shall:

a. Hold a current license in the state in which the optician practices as an ophthalmic dispenser;

b. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

c. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(3)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(4) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(5)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(6) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule;

or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 3. Reimbursement for Covered Procedures and Materials for Optometrists. (1) Except for [With the exception of materials or] a clinical laboratory service, the department's reimbursement for a covered service or covered item provided by a participating optometrist [within the optometrist's scope of licensure] shall be the lesser of the:

(a) Optometrist's usual and customary charge for the service or item; or

(b) Reimbursement established on the Department for Medicaid Services Vision Program Fee Schedule for the service or item.

(2) The department shall reimburse for a covered clinical laboratory service in accordance with 907 KAR 1:028 [based on the optometrist's usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using the Kentucky Medicaid fee schedule, specified in 907 KAR 3:010, Section 3, developed from a resource-based relative value scale (RBRVS) on parity with physicians.

(2) If an RBRVS-based fee has not been established, the department shall set a reasonable fixed upper limit for the procedure. The upper limit shall be determined following a review of rates paid for the service by three (3) other sources. The average of these rates shall be compared with similar procedures paid by the department to set the upper limit for the procedure.

(3) With the exception of the following dispensing services, the department shall use the Kentucky conversion factor for "all nonanesthesia-related services" as established in 907 KAR 3:010, Section 3(2)(b):

(a) Fitting of spectacles;

(b) Special spectacles fitting; and

(c) Repair and adjustment of spectacles.

(4) Reimbursement for a dispensing service fee or a repair service fee shall be as follows:

Procedure	Upper Limit
92340 (Fitting of spectacles)	\$33
92341 (Fitting of spectacles)	\$38
92352 (Special spectacles fitting)	\$33
92353 (Special spectacles fitting)	\$39
92370 (Repair & adjust spectacles)	\$29

(5) The department shall:

(a) Reimburse for:

1. A single vision lens at twenty-eight (28) dollars per lens;

2. A bifocal lens at forty-three (43) dollars per lens; and

3. A multi-focal lens at fifty-six (56) dollars per lens; and

(b) Annually adjust the rates established in paragraph (a) of this subsection by the Global Insight Index.

(6)(a) The department shall reimburse for frames or a part of frames (not lenses) at the optical laboratory cost of the materials not to exceed the upper limit for materials as established by the department.

(b) The upper payment limit for frames shall be fifty (50) dollars.

(c) An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for postpayment review.

(7)(a) Reimbursement for a covered clinical laboratory service shall be based on the Medicare allowable payment rates.

(b) For a laboratory service with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges].

Section 4.[3.] Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers. The department's reimbursement for a covered service or covered item provided by a participating ophthalmic dispenser [within the ophthalmic dispenser's scope of licensure] shall be the lesser of the:

(1) Ophthalmic dispenser's usual and customary charge for the service or item; or

(2) Reimbursement established on the Department for Medicaid Services Vision Program Fee Schedule for the service or item [in accordance with Section 2 of this administrative regulation].

Section 5.[4.] Reimbursement Limitations. (1) The department shall not reimburse for:

(a) A telephone consultation;

(b) [shall be excluded from payment]

(2) Contact lenses;

(c) [shall be excluded from payment]

(3) Safety glasses unless [shall be covered if] proof of medical necessity is documented;

(d) -

(4) A prism, if medically necessary, shall be added within the cost of the lenses.

(5) A press-on prism; or

(e) A service with a CPT code or item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule [shall be excluded from payment].

(2)(a) The department shall reimburse for no more than one (1) pair of eyeglasses per recipient per twelve (12) consecutive month period unless:

1. The recipient's eyeglasses are broken or lost during the twelve (12) consecutive month period; or

2. The eyeglass prescription for the recipient is changed during the twelve (12) consecutive month period.

(b) If an event referenced in paragraph (a) 1 or 2 of this subsection occurs within the twelve (12) consecutive month period, the department shall reimburse for one (1) additional pair of eyeglasses for the recipient during the twelve (12) consecutive month period.

(3) A prism, if medically necessary, shall be included in the cost of lenses.

Section 6.[5.] Third Party Liability. (1) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(2) A provider shall comply with KRS 205.622.

Section 7. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for an item or service reimbursed by the department via this administrative regulation.

Section 8. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 9.[6.] Appeal Rights. A provider may appeal a department decision as to the application of this administrative regulation~~(1) An appeal of a negative action taken by the department regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.~~

~~(2) An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

~~(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.~~

Section 10. Incorporation by Reference. (1) "Department for Medicaid Services Vision Program Fee Schedule", December 2013, 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, Monday

through Friday, 8 a.m. to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services' (DMS's) reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(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 DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(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 DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

(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 incorporates by reference a fee schedule which contains DMS's reimbursement for vision services; establishes that DMS will reimburse for one (1) pair of eyeglasses per year unless the pair is broken or lost or the prescription changes in which case DMS will reimburse for a second pair (currently, DMS in a related administrative regulation has an annual dollar limit of \$200 or \$400 for eyeglasses depending on the recipient's benefit plan); insert various program integrity measures; and establishes that reimbursement is contingent upon receiving federal approval/funding. This amended administrative regulation is being promulgated in conjunction with three (3) other administrative regulations - 907 KAR 1:632, Vision Program coverage provisions and requirements; 907 KAR 1:038, Hearing program coverage provisions and requirements; and 907 KAR

1:039, Hearing Program reimbursement provisions and requirements. 907 KAR 1:039 currently contains the \$200 and \$400 annual limit on eyeglasses, but vision program provisions are being removed from that administrative regulation as they will be addressed in this administrative regulation.

(b) The necessity of the amendment to this administrative regulation: Establishing a limit of one (1) pair of eyeglasses [or two (2) if the first pair is lost or the recipient's prescription changes] per year rather than an annual dollar cap (\$200 or \$400 as is currently stated in a related administrative regulation) is necessary to comply with an Affordable Care Act mandate. The mandate prohibits, effective January 1, 2014, annual dollar limits on health insurance benefits that are "essential health benefits." Medicaid program benefits are included in the scope of essential health benefits. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided. Additional amendments are necessary to incorporate various program integrity measures; clarify provisions and requirements; and to provide a user friendly fee schedule of reimbursement.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment will conform to the content of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by inserting program integrity measures; and by clarifying provisions and requirements.

(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 complying with a federal mandate; by preventing a potential loss of state funds; by inserting program integrity measures; and by clarifying provisions and requirements.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect vision service providers participating in the Kentucky Medicaid program. For calendar year 2012, twenty-two (22) opticians billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and 614 optometrists billed claims to the Medicaid program. 7,298 individuals (managed care and fee-for-service combined) received services from opticians in calendar year 2012 and 187,896 individuals received services from optometrists (managed care and fee-for-service combined) during the same period.

(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 the regulated entities other than properly billing for services and not violating program integrity requirements.

(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 may benefit by being allowed to have a pair of eyeglasses per year (with an additional pair allowed if the first pair is lost or the recipient's prescription changes) rather than be subject to a \$200 or \$400 annual cap on eyeglasses. Providers will benefit from a user friendly fee schedule.

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and

2014 will be similar to calendar year 2012 expenditures.

(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, state matching funds, 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: No increase in funding will be necessary to implement this administrative regulation.

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

(9) Tiering: Is tiering applied? Tiering is applied as eyeglass coverage is only available to those under twenty-one (21). 42 C.F.R. 441.56(c)(1) – which addresses early and periodic screening, diagnosis and treatment (EPSDT) services coverage – mandates coverage for individuals under twenty-one (21).

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 447.201, 42 C.F.R. 447.204, 42 C.F.R. 441.56(c)(1), 42 C.F.R. 441.30, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. KRS 194A.050(1) states, "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 205.520(3) states: "... 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. Vision services are not federally mandated except for those under age twenty-one (21) via the early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age twenty-one (21) program pursuant to 42 C.F.R. 441.56(c)(1). 42 C.F.R. 441.30 states, "The plan must provide for payment of optometric services as physician services, whether furnished by an optometrist or a physician, if—

(a) The plan does not provide for payment for services provided by an optometrist, except for eligibility determinations under §§435.531 and 436.531 of this subchapter, but did provide for those services at an earlier period; and

(b) The plan specifically provides that physicians' services include services an optometrist is legally authorized to perform." Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

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.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1), .

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 expects that the amendment will not generate revenue.

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

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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 Provider Operations (Amendment)

907 KAR 3:005. Coverage of physicians' services.

RELATES TO: KRS 205.520, 205.560, 42 C.F.R. 415.152, 415.174, 415.184, 440.50, 447.26, 45 C.F.R. 160, 164, 42 U.S.C. 1320 - 1320d-8, 1396a(a)(19), (30)

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

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 fundsfor

~~the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program coverage provisions and requirements~~[provisions] relating to physicians' services~~[for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and the medically needy].~~

Section 1. Definitions. (1) ["Biological" means the definition of "biologicals" pursuant to 42 U.S.C. 1395x(t)(1).

(2)] "Common practice" means a contractual partnership in which a physician assistant administers health care services under the employment and supervision of a physician.

(2)[(3) "Comprehensive choices" means a benefit plan for an individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022;

2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or

4. The Model Waiver II Program in accordance with 907 KAR 1:595; and

(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.

(4)] "CPT code" means a code used for reporting procedures and services performed by medical practitioners[physicians] and published annually by the American Medical Association in Current Procedural Terminology.

(3)[(5)] "Department" means the Department for Medicaid Services or its designee.

(4) "Designated controlled substance provider" means the provider designated as a lock-in recipient's controlled substance prescriber pursuant to 907 KAR 1:677.

(5) "Designated primary care provider" means the provider designated as a lock-in recipient's primary care provider pursuant to 907 KAR 1:677.

(6) "Direct physician contact" means that the billing physician is physically present with and evaluates, examines, treats, or diagnoses the recipient.

(7) "Early and periodic screening and diagnosis and treatment" or "EPSDT" is defined by 42 C.F.R. 440.40(b).["Drug" means the definition of "drugs" pursuant to 42 U.S.C. 1395x(t)(1-).]

(8) "Emergency care" means:

(a) Covered inpatient ~~or~~and]outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or

(b) Emergency ambulance transport.

(9) "Enrollee" means a recipient who is enrolled with a managed care organization.

(10) "Federal financial participation" is defined by 42 C.F.R. 400.203.["EPSDT" means early and periodic screening, diagnosis, and treatment.

(10) "Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to:

(a) 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u -1;

(b) 42 U.S.C. 1396a(a)(52) and 1396r - 6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

c. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

c. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

d. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

(e. Has a designated package code of 2, 3, 4, or 5.)

(11) "Global period" means [occurring during] the period of time in which related preoperative, intraoperative, and postoperative services and follow-up care for a surgical procedure are customarily provided.

(12) ~~"Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:~~

(a) ~~Caretaker relatives who:~~

1. ~~Receive Kentucky Transitional Assistance Program (K-TAP) benefits and are deprived due to death, incapacity, or absence;~~
2. ~~Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or~~
3. ~~Do not receive K-TAP benefits and are deprived due to unemployment;~~

(b) ~~Individuals aged sixty-five (65) and over who receive Supplemental Security Income (SSI) benefits and:~~

1. ~~Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~
2. ~~Receive State Supplementations Program (SSP) benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

(c) ~~Blind individuals who receive SSI benefits and:~~

1. ~~Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~
2. ~~SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

(d) ~~Disabled individuals who receive SSI benefits and:~~

1. ~~Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or~~
2. ~~SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

(e) ~~Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

(f) ~~Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;~~

(g) ~~Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022; or~~

(h) ~~Pregnant women.~~

(13) ~~"Graduate medical education program" or "GME Program" means [one (1) of the following]:~~

(a) ~~A residency program approved by:~~

1. ~~The Accreditation Council for Graduate Medical Education of the American Medical Association;~~
2. ~~The Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;~~
3. ~~The Commission on Dental Accreditation of the American Dental Association; or~~
4. ~~The Council on Podiatric Medicine Education of the American Podiatric Medical Association; or~~

(b) ~~An approved medical residency program as defined in 42 C.F.R. 413.75(b).~~

(13) ~~(14) "Incidental" means that a medical procedure is performed at the same time as a primary procedure and:~~

(a) ~~Requires little additional resources; or~~

(b) ~~Is clinically integral to the performance of the primary procedure.~~

(14) ~~(15) "Integral" means that a medical procedure represents a component of a more complex procedure performed at the same time.~~

(15) ~~"Lock-in recipient" means a recipient enrolled in the lock-in program in accordance with 907 KAR 1:677.~~

(16) ~~"KenPAC" means the Kentucky Patient Access and Care System.~~

(17) ~~"KenPAC PCP" means a Medicaid provider who is enrolled as a primary care provider in the Kentucky Patient Access and Care System.~~

(18) ~~"Locum tenens" means a substitute physician:~~

(a) ~~Who temporarily assumes responsibility for the professional practice of a physician participating in the Kentucky Medicaid Program; and~~

(b) ~~Whose services are paid under the participating physician's provider number.~~

(17) "Managed care organization" 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.

(18) "Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient as a Medicaid-participating provider in accordance with:

1. 907 KAR 1:671; and

2. 907 KAR 1:672;

(b) The Medicaid Program is the payer for the service; and

(c) The recipient is not liable for payment to the provider for the service other than any cost sharing obligation owed by the recipient to the provider.

(19) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(20) "Medical resident" means [one (1) of the following]:

(a) An individual who participates in an approved graduate medical education (GME) program in medicine or osteopathy; or

(b) A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, including:

1. An individual with a:

a. Temporary license;

b. Resident training license; or

c. Restricted license; or

2. An unlicensed graduate of a foreign medical school.

(21) "Mutually exclusive" means that two (2) procedures:

(a) Are not reasonably performed in conjunction with one another during the same patient encounter on the same date of service;

(b) Represent two (2) methods of performing the same procedure;

(c) Represent medically impossible or improbable use of CPT codes; or

(d) Are described in Current Procedural Terminology as inappropriate coding of procedure combinations.

(22) "Non-Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient;

(b) The Medicaid Program is not the payer for the service; and

(c) The recipient is liable for payment to the provider for the service.

(23) "Optimum choices" means a benefit plan for an individual who:

(a) Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. An intermediate care facility for individuals with an intellectual disability in accordance with 907 KAR 1:022; or

2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and

(c) Has a designated package code of S, T, U, V, W, X, Z, O, or 1-]

(24) ~~(23)~~ "Other licensed medical professional" means a health care provider other than a physician, physician assistant, advanced practice registered nurse [practitioner], certified registered nurse anesthetist, nurse midwife, or registered nurse who has been approved to practice a medical specialty by the appropriate licensure board.

(25) "Other provider preventable condition" is defined in 42 C.F.R. 447.26(b).

(26) ~~(24)~~ "Physician assistant" is defined in KRS 311.840(3).

(27) "Physician injectable drug" means an injectable, infused, or inhaled drug or biological that:

(a) Is not typically self-administered;

(b) Is not excluded as a noncovered immunization or vaccine;

(c) Requires special handling, storage, shipping, dosing, or administration; and

(d) Is a rebatable drug.

(28) "Podiatrist" is defined by KRS 205.510(12).

(29) "Rebatable drug" means a drug for which the drug's manufacturer has entered into or complied with a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(30) "Recipient" is defined by KRS 205.8541(9).

~~(31)[(25)]~~ "Screening" means the evaluation of a recipient by a physician to determine:

~~(a) If [The presence of] a disease or medical condition is present; and~~

~~(b) If further evaluation, diagnostic testing, or treatment is needed.~~

~~(32) [(26)] "Special handling, storage, shipping, dosing or administration" means one (1) or more of the following requirements as described in the dosing and administration section of a medication's package insert:~~

~~(a) Refrigeration of the medication;~~

~~(b) Protection from light until time of use;~~

~~(c) Overnight delivery;~~

~~(d) Avoidance of shaking or freezing; or~~

~~(e) Other protective measures not required for most orally-administered medications.~~

~~(27)] "Supervising physician" is defined in KRS 311.840(4).~~

~~(33)[(28)] "Supervision" is defined in KRS 311.840(6).~~

~~(34)[(29)] "Timely filing" means receipt of a Medicaid claim by the department[Medicaid]:~~

~~(a) Within twelve (12) months of the date the service was provided;~~

~~(b) Within twelve (12) months of the date retroactive eligibility was established; or~~

~~(c) Within six (6) months of the Medicare adjudication date if the service was billed to Medicare.~~

~~(35)[(30)] "Unlisted procedure or service" means a procedure:~~

~~(a) For which there is not a specific CPT code; and~~

~~(b) Which is billed using a CPT code designated for reporting unlisted procedures or services.~~

Section 2. Conditions of Participation. (1)(a) A participating physician shall:

1. Be licensed as a physician in the state in which the medical practice is located;

2. Comply with the:

a. Terms and conditions established in 907 KAR 1:005, 907 KAR 1:671, and 907 KAR 1:672;

b. Requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164;

3. Have the freedom to choose whether to provide services to a recipient; and

4. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any service to the recipient.

(b) A provider may provide a service to a recipient on a non-Medicaid basis:

1. If the recipient agrees to receive the service on a non-Medicaid basis; and

2. Whether or not the:

a. Provider is a Medicaid-participating provider; or

b. Service is a Medicaid-covered service.

(2) A participating physician shall comply with the terms and conditions established in the following administrative regulations:

(a) 907 KAR 1:005, Nonduplication of payments;

(b) 907 KAR 1:671, Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions; and

(c) 907 KAR 1:672, Provider enrollment, disclosure, and documentation for Medicaid participation.

(3) A participating physician shall comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.

(4) A participating physician shall have the freedom to choose whether to accept an eligible Medicaid recipient and shall notify the recipient of that decision prior to the delivery of service. If a provider agrees to provide services to a recipient, the provider:

(a) Shall bill the department[Medicaid] rather than the recipient for a covered service;

(b) May bill the recipient for a service not covered by Medicaid

if the physician informed the recipient of noncoverage prior to providing the service; and

(c) Shall not bill the recipient for a service that is denied by the department on the basis of:

1. The service being incidental, integral, or mutually exclusive to a covered service or within the global period for a covered service;

2. Incorrect billing procedures, including incorrect bundling of services;

3. Failure to obtain prior authorization for the service; or

4. Failure to meet timely filing requirements.

(3)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(4)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(5)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(6) A provider shall comply with 45 C.F.R. Part 164.

Section 3. Covered Services. (1) To be covered by the department, a service shall be:

(a) Medically necessary;

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;

(c) Except as provided in subsection (2) of this section, furnished to a recipient through direct physician contact; and

(d) Eligible for reimbursement as a physician service.

(2) Direct physician contact between the billing physician and recipient shall not be required for:

(a) A service provided by a:

1. Medical resident if provided under the direction of a program participating teaching physician in accordance with 42 C.F.R. 415.174 and 415.184;

2. (b) A service provided by a locum tenens physician who provides direct physician contact; or

3. Physician assistant in accordance with Section 7 of this administrative regulation;

(b) (e) A radiology service, imaging service, pathology service, ultrasound study, echographic study, electrocardiogram, electromyogram, electroencephalogram, vascular study, or other service that is usually and customarily performed without direct physician contact;

(c) (d) The telephone analysis of emergency medical systems or a cardiac pacemaker if provided under physician direction;

(d) (e) A [preauthorized] sleep disorder service if provided in a physician operated and supervised sleep disorder diagnostic center; or

(e) (f) A telehealth consultation provided [by a consulting medical specialist] in accordance with 907 KAR 3:170; or

(g) A service provided by a physician assistant in accordance with Section 7 of this administrative regulation.

(3) A service provided by an [individual who meets the definition of] other licensed medical professional shall be covered if the other licensed medical professional is:

- (a) ~~[The individual is]~~Employed by the supervising physician;
and
(b) ~~[The individual is]~~Licensed in the state of practice; and
(c) ~~The supervising physician has direct physician contact with the recipient].~~
(4) A sleep disorder service shall be covered if performed in:
(a) A hospital; or
(b)1. A sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the:
a. American Sleep Disorders Association; or
b. American Academy of Sleep Medicine; or
2. An independent diagnostic testing facility that:
a. Is supervised by a physician trained in analyzing and interpreting sleep disorder recordings; and
b. Has documentation demonstrating that it complies with criteria approved by the:
(i) American Sleep Disorders Association; or
(ii) American Academy of Sleep Medicine

Section 4. Service Limitations. (1) A covered service provided to a lock-in recipient ~~[placed in "lock-in" status in accordance with 907 KAR 1:677]~~shall be limited to a service provided by the lock-in recipient's designated primary care provider or designated controlled substance prescriber~~[lock-in provider]~~ unless:

- (a) The service represents emergency care; or
(b) The lock-in recipient has been referred to the provider by the lock-in recipient's designated primary care provider~~[by the "lock-in" provider]~~.
(2) An EPSDT screening service shall be covered in accordance with 907 KAR 11:034~~[Sections 3 through 5]~~.
(3) A laboratory procedure performed in a physician's office shall be limited to a procedure for which the physician has been certified in accordance with 42 C.F.R. Part 493.
(4) ~~[Except for the following, a drug administered in the physician's office shall not be covered as a separate reimbursable service through the physician program:~~
(a) Rho (D) immune globulin injection;
(b) An injectable antineoplastic drug;
(c) Medroxyprogesterone acetate for contraceptive use, 150 mg;
(d) Penicillin G benzathine injection;
(e) Ceftriaxone sodium injection;
(f) Intravenous immune globulin injection;
(g) Sodium hyaluronate or hylan G-F for intra-articular injection;
(h) An intrauterine contraceptive device; or
(i) An implantable contraceptive device
(j) Long acting injectable risperidone; or
(k) An injectable, infused or inhaled drug or biological that:
1. Is not typically self-administered;
2. Is not excluded as a noncovered immunization or vaccine;
and

3. Requires special handling, storage, shipping, dosing or administration.

(5) A service allowed in accordance with 42 C.F.R. 441, Subpart E or Subpart F, shall be covered within the scope and limitations of 42 C.F.R. 441, Subpart E and Subpart F~~[the federal regulations]~~.

(5)~~[(6)]~~ Coverage for:
(a) A service designated as a psychiatry service CPT code and provided by a physician other than a board certified or board eligible psychiatrist or an advanced practice registered nurse with a specialty in psychiatry shall be limited to four (4) services, per physician, per recipient, per twelve (12) months;
(b)~~[-~~

(7)(a) ~~Coverage for~~ An evaluation and management service shall be limited to one (1) per physician, per recipient, per date of service; or
(c)~~[-~~

(b) Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician.

~~(8) Coverage for~~ A fetal diagnostic ultrasound procedure shall be limited to two (2) per nine (9) month period per recipient unless the diagnosis code justifies the medical necessity of an additional procedure.

(6)~~[(9)(a)]~~ An anesthesia service shall be covered if:
(a) Administered by:
1. An anesthesiologist who remains in attendance throughout the procedure; or
2. An individual who:
a. Is licensed in Kentucky to practice anesthesia;
b. Is licensed in Kentucky within his or her scope of practice;
and

c. Remains in attendance throughout the procedure;
(b) Medically necessary; and
(c) Not provided as part of an all-inclusive CPT code.
(7)~~[administered by an anesthesiologist who remains in attendance throughout the procedure;~~

(b) ~~Except for An anesthesia service provided by an oral surgeon, an anesthesia service, including conscious sedation, provided by a physician performing the surgery shall not be covered.~~

(10) The following ~~[services]~~shall not be covered:

- (a) An acupuncture service;
(b) ~~[Allergy immunotherapy for a recipient age twenty-one (21) years or older;~~
(c) An autopsy;
(c)~~[(d)]~~ A cast or splint application in excess of the limits established in 907 KAR 3:010~~[, Section 4(5) and (6)]~~;
(d)~~[(e)]~~ Except for therapeutic bandage lenses, contact lenses;
(e)~~[(f)]~~ A hysterectomy performed for the purpose of sterilization;
(f)~~[(g)]~~ Lasik surgery;
(g)~~[(h)]~~ Paternity testing;
(h)~~[(i)]~~ A procedure performed for cosmetic purposes only;
(i)~~[(j)]~~ A procedure performed to promote or improve fertility;
(j)~~[(k)]~~ Radial keratotomy;
(k)~~[(l)]~~ A thermogram;
(l)~~[(m)]~~ An experimental service which is not in accordance with current standards of medical practice; ~~[or]~~
(m)~~[(n)]~~ A service which does not meet the requirements established in Section 3(1) of this administrative regulation;
(n) Medical direction of an anesthesia service; or
(o) Medical assistance for an other provider preventable condition in accordance with 907 KAR 14:005.

Section 5. Prior Authorization Requirements for Recipients Who are Not Enrolled with a Managed Care Organization~~[and KenPAC Referral Requirements]~~. (1) The following procedures for a recipient who is not enrolled with a managed care organization shall require prior authorization by the department:

- (a) Magnetic resonance imaging~~[(MRI)]~~;
(b) Magnetic resonance angiogram~~[(MRA)]~~;
(c) Magnetic resonance spectroscopy;
(d) Positron emission tomography~~[(PET)]~~;
(e) Cineradiography or videoradiography~~[video radiography]~~;
(f) Xeroradiography;
(g) Ultrasound subsequent to second obstetric ultrasound;
(h) Myocardial imaging;
(i) Cardiac blood pool imaging;
(j) Radiopharmaceutical procedures;
(k) Gastric restrictive surgery or gastric bypass surgery;
(l) A procedure that is commonly performed for cosmetic purposes;
(m) A surgical procedure that requires completion of a federal consent form; or
(n) An unlisted covered procedure or service.
(2)(a) Prior authorization by the department shall not be a guarantee of recipient eligibility.
(b) Eligibility verification shall be the responsibility of the provider.
(3) The prior authorization requirements established in subsection (1) of this section shall not apply to:
(a) An emergency service; or

(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code.

(4) A referring physician, a physician who wishes to provide a given service, a podiatrist, a chiropractor, or an advanced practice registered nurse;

(a)[practitioner] May request prior authorization from the department; and

(b) If requesting prior authorization; -

~~(5) A referring physician, a physician who wishes to provide a given service, or an advanced registered nurse practitioner shall request prior authorization by;~~

1. Mailing or faxing:

a. [(a)] A written request to the department with [sufficient]information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation; and

b. [(b)] If applicable, any required federal consent forms; or

2. Submitting a request via the department's web-based portal with information sufficient to demonstrate that the service meets the requirements established in Section 3(1) of this administrative regulation. [(6) Except for a service specified in 907 KAR 1:320, Section 10(3)(a) through (q), a referral from the KenPAC PCP shall be required for a recipient enrolled in the KenPAC Program.]

Section 6. Therapy Service Limits. (1) Speech language pathology services[therapy] shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section];

(a) Ten (10) visits per twelve (12) months for a recipient of the Global Choices benefit plan;

(b) Thirty (30) visits per twelve (12) months for a recipient of the:

1. Comprehensive Choices benefit plan; or

2. Optimum Choices benefit plan].

(2) Physical therapy services shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section];

(a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices benefit plan; or

(b) Thirty (30) visits per twelve (12) months for a recipient of the:

1. Comprehensive Choices benefit plan; or

2. Optimum Choices benefit plan].

(3) Occupational therapy services shall be limited to twenty (20) service visits per recipient per calendar year except as established in subsection (4) of this section];

(a) Fifteen (15) visits per twelve (12) months for a recipient of the Global Choices benefit plan; or

(b) Thirty (30) visits per twelve (12) months for a recipient of the:

1. Comprehensive Choices benefit plan; or

2. Optimum Choices benefit plan].

(4) A service in excess of the [therapy] limits established in subsection (1) through (3) of this section shall be exceeded[over-ridden] if the additional service is determined to be medically necessary by:

(a) The department if the recipient is not enrolled with a managed care organization; or

(b) Managed care organization in which the enrollee is enrolled if the recipient is an enrollee[determines that additional visits beyond the limit are medically necessary. (5)(a) To request an override:

1. The provider shall telephone or fax the request to the department; and

2. The department shall review the request in accordance with the provisions of 907 KAR 3:130 and notify the provider of its decision.

(b) An appeal of a denial regarding a requested override shall be in accordance with 907 KAR 1:563.

(6) The limits established in subsections (1), (2), and (3) of this section shall not apply to a recipient under twenty-one (21) years of age. Except for recipients under age twenty-one (21), prior authorization shall be required for each visit that exceeds the limit

established in subsection (1) through (3) of this section].

Section 7. Physician Assistant Services. (1) Except for[With the exception of] a service limitation specified in subsections (2) or (3) of this section, a service provided by a physician assistant in common practice with a Medicaid-enrolled physician shall be covered if:

(a) The service meets the requirements established in Section 3(1) of this administrative regulation;

(b) The service is within the legal scope of certification of the physician assistant;

(c) The service is billed under the physician's individual provider number with the physician assistant's number included; and

(d) The physician assistant complies with:

1. KRS 311.840 to 311.862; and

2. Section 2(1)(b)[Sections 2(2) and (3)] of this administrative regulation.

(2) A same service performed by a physician assistant and a physician on the same day within a common practice shall be considered as one (1) covered service.

(3) The following physician assistant services shall not be covered:

(a) A physician noncovered service specified in Section 4(9)[Section 4(10)] of this administrative regulation;

(b) An anesthesia service;

(c) An obstetrical delivery service; or

(d) A service provided in assistance of surgery.

Section 8. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the same service provided to the same recipient during the same time period via the physician services program.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. 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 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, or 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 11. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 12. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 13. Appeal Rights. [(+)] An appeal of a department decision regarding:

(1) A Medicaid recipient who is not enrolled with a managed care organization based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:563; or

(2) An enrollee based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:510. [(2) An appeal of a department decision regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

(3) 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 1:674.]

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid program coverage provisions and requirements regarding physician services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the Medicaid program coverage provisions and requirements regarding physician 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 Medicaid program coverage provisions and requirements regarding physician 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 authorizing statutes by establishing the Medicaid program coverage provisions and requirements regarding physician 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 amendments include authorizing Medicaid reimbursement for allergy immunotherapy for all ages [the current version of the administrative regulation does not authorize such

coverage for individuals twenty-one (21) and over]; revising the speech pathology service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; revising the physical therapy service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; revising the occupational therapy service limit from ten (10) visits per twelve (12) months for global choices individuals, thirty (30) visits per twelve (12) months for comprehensive choices individuals and optimum choices individuals, and no limit for family choices individuals to twenty (20) visits per calendar year for all Medicaid recipients; deleting references to the four (4) Medicaid benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years; establishing that the Department for Medicaid Services (DMS) won't reimburse for medical direction of an anesthesia service and won't reimburse for an anesthesia service that is included as part of an all-inclusive CPT code; establishing that a sleep disorder service must be performed in a hospital, sleep laboratory if the sleep laboratory has documentation demonstrating that it complies with criteria approved by the American Sleep Disorders Association or American Academy of Sleep Medicine, or independent diagnostic testing facility that is supervised by a physician training in analyzing and interpreting sleep disorder recordings and if the testing facility has the aforementioned documentation required for sleep laboratories; establishing that DMS won't reimburse for an "other provider preventable condition" (this is a condition which resulted from a provider's neglect and was not present in the recipient when the recipient appeared at the provider's office to receive a service); adding podiatrists and chiropractors as providers eligible to request prior authorization for a service; establishing an option for providers to request prior authorization for services through an internet portal; establishing that the Department for Medicaid Services' (DMS's) coverage of services is contingent upon federal approval and funding; and establishing that the relevant administrative regulation for services' related appeals for an individual who is enrolled with a managed care organization is 907 KAR 17:010.

(b) The necessity of the amendment to this administrative regulation: The amendment which eliminates the age cap on allergy immunotherapy and the amendment which sets a uniform limit of twenty (20) therapy service visits per calendar year are necessary to synchronize DMS's coverage of therapy services and of allergy immunotherapy with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy

service limit of twenty (20) visits per recipient per calendar year and covers allergy immunotherapy for all ages, DMS is adopting the same policies. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) Consequently, DMS is concurrently repealing the administrative regulation which establishes the four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years. The four (4) benefit plans vary little and DMS is establishing one (1) benefit plan for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. Additionally, there is an administrative and Medicaid Management Information System (MMIS) burden associated with preserving different plans as well as an administrative burden on providers and managed care organizations. Given that the plans vary little it is impractical if not inefficient to preserve the plans. The amendments regarding anesthesia are necessary to ensure appropriate utilization of services. The amendment regarding a sleep disorder service is necessary to ensure recipients are served by a provider that meets national industry standards. Establishing that DMS won't reimburse for an "other provider preventable condition" is necessary to comply with a federal mandate. Authorizing chiropractors and podiatrists to request prior authorization is necessary to enhance recipient access to services; establishing an option for providers to request prior authorization online is necessary to expedite the delivery of services; establishing that DMS's coverage of services is contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer monies; and establishing that appeals for a recipient enrolled with a managed care organization will be done in accordance with the relevant managed care organization regulation is necessary as such appeals are in the domain of managed care organizations.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting with the Affordable Care Act, enhancing the health, safety, and welfare of Medicaid recipients, facilitating providers' ability to request prior authorizations, and protecting Kentucky taxpayer monies.

(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 comporting with the Affordable Care Act, enhancing the health, safety, and welfare of Medicaid recipients, facilitating providers' ability to request prior authorizations, and protecting Kentucky taxpayer monies.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The administrative regulation affects physicians enrolled in the Medicaid program. Currently, there are over 14,000 individual physicians and over 1,700 physician group practices participating in the Medicaid Program. Medicaid recipients who receive services (including physical therapy services, speech pathology services, or sleep disorder services) will be affected by the amendment.

(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 by providers other than to ensure that they provide services appropriately in accordance with the program requirements.

(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 providers.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): As a result of complying with the administrative regulation, Medicaid-enrolled physicians will be reimbursed for services provided to Medicaid recipients.

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

(a) Initially: The Department for Medicaid Services (DMS) anticipates no additional cost as a result of the amendment.

(b) On a continuing basis: DMS anticipates no additional cost as a result of the amendment.

(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 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: The current fiscal year budget will not need to be adjusted to provide funds for implementing this administrative regulation.

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

(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.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(10), 42 U.S.C. 1396a(a)(19), and 42 C.F.R. 447.26.

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. 42 U.S.C. 1396a(a)(10) mandates that a state's Medicaid Program cover physician services. 42 U.S.C. 1396a(a)(19) requires Medicaid programs to provide care and services consistent with the best interests of Medicaid recipients.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment will affect all physicians enrolled in the Medicaid program who are not reimbursed via a managed care organization.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This amendment is authorized by 42 C.F.R. 447.26 and 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 amendment will not generate any additional revenue for state or local governments during the first year of implementation.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent

years? This amendment will not generate any additional revenue for state or local governments during subsequent years of implementation.

(c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment.

(d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional 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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amendment)

907 KAR 10:014. Outpatient hospital service coverage provisions and requirements.

RELATES TO: KRS 205.520, 42 C.F.R. 447.53

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560, 205.6310, 205.8453

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 empowers the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[for the provision of medical assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the Medicaid Program service and coverage policies for outpatient hospital services[provisions relating to outpatient hospital services for which payment shall be made by the medical assistance program on behalf of the categorically needy and medically needy].

Section 1. Definitions. (1) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.["Comprehensive choices" means a benefit plan for an individual who:

(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. A nursing facility in accordance with 907 KAR 1:022;

2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;

3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160;

4. The Model Waiver II Program in accordance with 907 KAR 1:595;

5. The Acquired Brain Injury Long Term Care Waiver Program in accordance with 907 KAR 3:210; or

6. The Michelle P. Waiver Program in accordance with 907 KAR 1:835; and

(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.]

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

(3) "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.

(4) "Emergency medical condition" is defined by 42 U.S.C. 1395dd(e)(1).

(5) "Enrollee" means a recipient who is enrolled with a managed care organization["Family choices" means a benefit plan for an individual who:

(a) Is covered pursuant to:

1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;

2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);

3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);

4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);

5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or

6. 42 C.F.R. 457.310; and

(b) Has a designated package code of 2, 3, 4, or 5].

(6) "Federal financial participation" is defined by 42 C.F.R. 400.203["Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:

(a) Caretaker relatives who:

1. Receive K-TAP and are deprived due to death, incapacity, or absence;

2. Do not receive K-TAP and are deprived due to death, incapacity, or absence; or

3. Do not receive K-TAP and are deprived due to unemployment;

(b) Individuals aged sixty-five (65) and over who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. Receive SSP and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(c) Blind individuals who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or

2. SSP, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(d) Disabled individuals who receive SSI and:

1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or

2. SSP, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;

(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;

(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022; or

(h) Pregnant women].

(7) "Lock-in recipient" means a recipient enrolled in the department's lock-in program pursuant to 907 KAR 1:677.

(8) "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53.

(10) "Provider" is defined by KRS 205.8451(7)["Optimum choices" means a benefit plan for an individual who:

(a) Meets the intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022;

(b) Receives services through either:

1. An intermediate care facility for individuals with an intellectual disability patient status criteria established in 907 KAR 1:022; or

2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and

(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1].

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

- (12) "Unlisted procedure or service" means a procedure;
 (a) For which there is not a specific CPT code; and
 (b) Which is billed using a CPT code designated for reporting unlisted procedures or services.

Section 2. Coverage Criteria. (1) To be covered by the department:

(a) The following[~~services~~] shall be prior authorized and meet the requirements established in paragraph (b) of this subsection:

1. Magnetic resonance imaging[~~(MRI)~~];
2. Magnetic resonance angiogram[~~(MRA)~~];
3. Magnetic resonance spectroscopy;
4. Positron emission tomography[~~(PET)~~];
5. Cineradiography/videoradiography;
6. Xeroradiography;
7. Ultrasound subsequent to second obstetric ultrasound;
8. Myocardial imaging;
9. Cardiac blood pool imaging;
10. Radiopharmaceutical procedures;
11. Gastric restrictive surgery or gastric bypass surgery;

12. A procedure that is commonly performed for cosmetic purposes;

13. A surgical procedure that requires completion of a federal consent form; or

14. An unlisted procedure or service; and

(b) An outpatient hospital service, including those identified in paragraph (a) of this subsection, shall be:

1. ~~a.~~ Medically necessary; and

~~b.[2.]~~ Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and

~~2.[3.]~~ For a lock-in recipient:

a. Provided by the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

b. A screening or emergency service that meets the requirements of subsection (6)(a) of this ~~section~~[subsection].

(2) The prior authorization requirements established in subsection (1) of this section shall not apply to:

(a) An emergency service;

(b) A radiology procedure if the recipient has a cancer or transplant diagnosis code; or

(c) A service provided to a recipient in an observation bed.

(3) A referring physician, a physician who wishes to provide a given service, or an advanced practice registered nurse may request prior authorization from the department.

(4) The following covered hospital outpatient services shall be furnished by or under the supervision of a duly licensed physician, or if applicable, a duly-licensed dentist:

(a) A diagnostic service ordered by a physician;

(b) A therapeutic service, except for occupational therapy services as occupational therapy services shall not be covered under this administrative regulation, ordered by a physician;

(c) An emergency room service provided in an emergency situation as determined by a physician; or

(d) A drug, biological, or injection administered in the outpatient hospital setting.

(5) A covered hospital outpatient service for maternity care may be provided by:

(a) An advanced practice registered nurse[~~(APRN)~~] who has been designated by the Kentucky Board of Nursing as a nurse midwife; or

(b) A registered nurse who holds a valid and effective permit to practice nurse midwifery issued by the Cabinet for Health and Family Services.

(6) The department shall cover:

(a) A screening of a lock-in recipient to determine if the lock-in recipient has an emergency medical condition; or

(b) An emergency service to a lock-in recipient if the department determines that the lock-in recipient had an emergency medical condition when the service was provided.

Section 3. Hospital Outpatient Services Not Covered by the Department. The following services shall not be considered a covered hospital outpatient service:

(1) An item or service that does not meet the requirements established in Section 2(1) of this administrative regulation;

(2) A service for which:

(a) An individual has no obligation to pay; and

(b) No other person has a legal obligation to pay;

(3) A medical supply or appliance, unless it is incidental to the performance of a procedure or service in the hospital outpatient department and included in the rate of payment established by the Medical Assistance Program for hospital outpatient services;

(4) A drug, biological, or injection purchased by or dispensed to a recipient[patient];

(5) A routine physical examination;[or]

(6) A nonemergency service, other than a screening in accordance with Section 2(6)(a) of this administrative regulation, provided to a lock-in recipient:

1. In an emergency department of a hospital; or

2. If provided by a hospital that is not the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

(7) Occupational therapy services.

Section 4. Therapy Limits. (1) Speech language pathology services[therapy] shall be limited to twenty (20) service[:

~~(a) Ten (10)] visits per calendar year per~~[twelve (12) months for a] recipient[~~of the Global Choices benefit package; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit package; or~~

~~2. Optimum Choices benefit package].~~

(2) Physical therapy services shall be limited to twenty (20) service[:

~~(a) Fifteen (15)] visits per calendar year per~~[twelve (12) months for a] recipient[~~of the Global Choices benefit package; or~~

~~(b) Thirty (30) visits per twelve (12) months for a recipient of the:~~

~~1. Comprehensive Choices benefit package; or~~

~~2. Optimum Choices benefit package].~~

(3) A service in excess of the limits established in subsection (1) and (2) of this section shall be approved if the service in excess of the limits is determined to be medically necessary by the:

(a) Department if the recipient is not enrolled with a managed care organization; or

(b) Managed care organization in which the enrollee is enrolled if the recipient is an enrollee[The therapy limits established in subsections (1) and (2) of this section shall be over-ridden if the department determines that additional visits beyond the limit are medically necessary-]

~~(a) To request an override:~~

~~1. The provider shall telephone or fax the request to the department; and~~

~~2. The department shall review the request in accordance with the provisions of 907 KAR 3:130 and notify the provider of its decision.~~

~~(b) An appeal of a denial regarding a requested override shall be in accordance with 907 KAR 1:563].~~

~~(4)[Except for recipients under age twenty-one (21),] Prior authorization by the department shall be required for each service visit that exceeds the limit established in subsections (1) and (2) of this section for a recipient who is not enrolled with a managed care organization~~[(5) The limits established in subsections (1) and (2) of this section shall not apply to a recipient under twenty-one (21) years of age].

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving speech therapy from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for speech therapy provided to the same recipient during the same time period via the outpatient hospital services program.

Section 6. Records Maintenance, Protection, and Security.

(1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Part 164.

Section 7. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 8. Third Party Liability. A provider shall comply with KRS 205.622.

Section 9. 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 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, or 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 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 10. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeals. (1) An appeal of an adverse action by the

department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding outpatient hospital services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding outpatient hospital 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 Medicaid Program coverage provisions and requirements regarding outpatient hospital services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital 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 primary amendment sets a uniform limit [of twenty (20) physical therapy service visits or speech pathology service visits per recipient per calendar year] in lieu of the existing varied limits ranging from ten (10) to thirty (30) visits per recipient per month based on the benefit plan of the given recipient. The amendment preserves the existing option for recipients to receive services above the limits if additional services are medically necessary and prior authorized. Additional amendments include deleting references to the four (4) Medicaid benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years; establishing that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to the same recipient by two (2) different providers at the same time; inserting records maintenance and

relate confidentiality of medical records requirements; establishing that if third party liability exists for a given recipient that the provider is to bill the third party; establishing electronic signature requirements; and establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding; and inserting an appeals section for recipients regarding services being denied.

(b) The necessity of the amendment to this administrative regulation: Replacing the varying speech pathology service and physical therapy service limits with a uniform limit of twenty (20) service visits per recipient per calendar year is necessary to synchronize the Department for Medicaid Services' coverage of services with the alternative benefit plan established by DMS to be effective January 1, 2014. An alternative benefit plan is mandated by the Affordable Care Act for any state which adds the Medicaid "expansion group" to its eligibility groups. The alternative benefit plan is the array of benefits available to the expansion group and must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year, DMS is adopting the same limit. Also, DMS is adopting the same benefit plan for all Medicaid recipients (those eligible under the "old" rules as well as under the "new" rules.) Consequently, DMS is concurrently repealing the administrative regulation which establishes the four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices – to which Medicaid recipients have been assigned for the past several years. The four (4) benefit plans vary little and DMS is establishing one (1) benefit plan for all Medicaid recipients including the new groups mandated or authorized by the Affordable Care Act. Additionally, there is an administrative and Medicaid Management Information System (MMIS) burden associated with preserving different plans as well as an administrative burden on providers and managed care organizations. Given that the plans vary little it is impractical if not inefficient to preserve the plans. The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided. Establishing an appeals section for recipients is necessary to reinforce that recipients have appeals' rights regarding services being denied.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comports with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the

authorizing statutes by comports with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Outpatient hospitals will be affected by the amendment as will Medicaid recipients who receive physical therapy services or speech pathology services via the outpatient hospital program. Currently, there are 106 hospitals located in Kentucky and participating in the Medicaid Program. Over 20,000 Medicaid recipients received physical therapy services via the outpatient hospital program in the most recently completed state fiscal year. Over 4,300 Medicaid recipients received speech pathology services via the outpatient hospital program in the most recently completed state fiscal year.

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

(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 or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Outpatient hospitals will benefit from a simpler service limit structure as there will be one limit for all rather than variances due to four (4) different benefit plans.

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

(a) Initially: DMS cannot accurately predict the future utilization of outpatient hospital services, but in the most recently completed state fiscal year DMS spent approximately \$77 million (state and federal funds combined) on outpatient hospital services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent almost \$455.4 million (state and federal funds combined.) Of the nearly \$77 million spent by DMS on outpatient hospital services, over \$1.2 million (state and federal funds combined) was spent on physical therapy services; and over \$596,000 was spent on speech pathology services. Of the almost \$455.4 million spent by MCOs in aggregate on outpatient hospital services, almost \$6.9 million was spent on physical therapy services and over \$1.9 million was spent on speech pathology services.

(b) On a continuing basis: Please see the response to question (a).

(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 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: 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 the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.210 and 42 C.F.R. 440.220.

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. Medicaid programs are required to cover outpatient hospital services.

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? Some hospitals are owned by local government entities, but DMS is unable to accurately predict the impact of this amendment as revenues will depend on utilization of services. Given that more individuals will be eligible for Medicaid services (not as a result of the amendment to this administrative regulation though) utilization is expected to increase; thus, an increase in revenues is a logical expectation.

(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? Please see the response to question (b).

(c) How much will it cost to administer this program for the first year? DMS cannot accurately predict the future utilization of outpatient hospital services, but in the most recently completed state fiscal year DMS spent approximately \$77 million (state and federal funds combined) on outpatient hospital services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent almost \$455.4 million (state and federal funds combined.) Of the nearly \$77 million spent by DMS on outpatient hospital services, over \$1.2 million (state and federal funds combined) was spent on physical therapy services; and over \$596,000 was spent on speech pathology services. Of the almost \$455.4 million spent by MCOs in aggregate on outpatient hospital services, almost \$6.9 million was spent on physical therapy services and over \$1.9 million was spent on speech pathology services.

(d) How much will it cost to administer this program for subsequent years? Please see the response to question (c).

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:

NEW ADMINISTRATIVE REGULATIONS

OFFICE OF THE GOVERNOR
Department for Local Government
(New Administrative Regulation)

109 KAR 16:010. Special purpose governmental entities.

RELATES TO: KRS 65A.010, 65A.020, 65A.030, 65A.040, 65A.090

STATUTORY AUTHORITY: KRS 65A.020

NECESSITY, FUNCTION, AND CONFORMITY: KRS 65A.020(3)(a) requires the Department for Local Government to promulgate administrative regulations to develop standard forms, protocols, timeframes, and due dates for the submission of information by special purpose governmental entities. This administrative regulation establishes the format for financial disclosure by special purpose governmental entities and prescribes the protocols, timeframes, and due dates for submission of information by special purpose governmental entities.

Section 1. Definitions. (1) "Annual revenue" means all revenue, from whatever source, received by the special purpose governmental entity during the most recent fiscal period for which data is available, as reflected in the budget to actual portion of DLG Form SPGE 101 required by Section 4(1) of this administrative regulation.

(2) "Budget" means the estimated revenues and appropriations for a fiscal period.

(3) "DLG" is defined by KRS 65A.010(2).

(4) "Fiscal period" means the fiscal year adopted by the special purpose governmental entity for budgeting purposes.

(5) "Registry" is defined by KRS 65A.010(7).

(6) "Special purpose governmental entity" or "SPGE" is defined by KRS 65A.010(8).

Section 2. Registration with the Department for Local Government. (1) All special purpose governmental entities in existence prior to December 31, 2013 shall, prior to December 31, 2013, complete and submit DLG Form SPGE 100 Special Purpose Governmental Entity Registration and Board Reporting Form. The information shall be submitted in the same manner as required by Section 3(1) of this administrative regulation. The DLG may allow an alternative form of submission as provided in Section 3(2) of this administrative regulation. This submission shall serve as the initial registration required by KRS 65A.090(1).

(2) A special purpose governmental entity established after December 31, 2013 shall complete and submit DLG Form SPGE 100 Special Purpose Governmental Entity Registration and Board Reporting Form within fifteen (15) days of the establishment of the entity. The form shall be submitted as provided in subsection (1) of this section.

Section 3. Electronic submission required; exceptions. (1) Except as provided by subsections (2) and (3) of this section, all information required to be submitted to the DLG shall be submitted electronically, using the information reporting portal on the DLG Web site at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm>.

(2) A special purpose governmental entity may request approval from the DLG to submit required information by alternative means. The request shall be in writing, and shall:

(a) State the name of the special purpose governmental entity;

(b) List all information for which an alternative means of submission is sought;

(c) Be made by the governing body of the special purpose governmental entity;

(d) Be received by the DLG at least sixty (60) days before the information to which the request relates is due;

(e) State the reason why the required information cannot be submitted using the standard electronic submission format; and

(f) Identify the method of submission proposed.

(3)(a) Approval of an alternative submission method shall be at

the discretion of the DLG. If the DLG approves an alternative submission method, the special purpose governmental entity shall submit the information in the form and format determined by the DLG and communicated to the special purpose governmental entity as part of the approval process.

(b) The DLG may withdraw approval to use an alternative reporting method at any time by providing written notice of the withdrawal of approval to the special purpose governmental entity at least thirty (30) days prior to the effective date of the withdrawal of approval.

Section 4. Requirements for Submission of Administrative and Financial Information. For each fiscal period beginning on or after July 1, 2014, each special purpose governmental entity shall annually submit information for publication on the registry as required by this section. (1) Within fifteen (15) days following the beginning of each fiscal period, the SPGE shall submit the administrative information required by KRS 65A.020(2)(a)1, using Section I of DLG Form SPGE 101.

(2) The SPGE shall submit the budget information required by KRS 65A.020(2)(a)1 using DLG Form SPGE 101 and shall submit the budget information as required by this subsection.

(a) Each special purpose governmental entity shall submit its adopted budget to the DLG within fifteen (15) days following the beginning of the fiscal period for which the adopted budget applies.

(b) Each special purpose governmental entity shall submit a comparison of the adopted budget to actual revenues and expenditures for each fiscal period within sixty (60) days following the close of each fiscal period.

(c) The comparison of the adopted budget to actual revenues and expenditures shall be reflected on the budget to actual portion of SPGE 101.

(3) Within fifteen (15) days following the beginning of each fiscal period, each SPGE shall submit the financial information required by KRS 65A.020(2)(a)2. This information shall be submitted using DLG Form SPGE 101 and shall list all taxes, fees, or charges imposed and collected by the entity, including the rates or amounts charged for the reporting period and the statutory authority for the levy of the tax, fee, or charge.

Section 5. Submission of Audits and Attestation Engagements.

(1) An audit or attestation engagement required to be submitted for publication on the registry pursuant to KRS 65A.030 shall be submitted to the DLG within fifteen (15) days following receipt of the completed audit or attestation engagement by the special purpose governmental entity.

(2)(a) A special purpose governmental entity required by KRS 65A.030(1)(a)(2) to contract for the provision of an attestation engagement shall ensure that it receives the attestation engagement no later than July 1, 2018, or, for an attestation engagement required by KRS 65A.030(1)(a)(2) after July 1, 2018, no more than four (4) years from the date of the special purpose governmental entity's last attestation engagement.

(b) A special purpose governmental entity required by KRS 65A.030(1)(b)(2) to contract for the provision of an independent audit shall ensure that it receives the independent audit no later than July 1, 2018, or, for an independent audit required by KRS 65A.030(1)(b)(2) after July 1, 2018, no more than four (4) years from the date of either:

1. The entity's last independent audit, or

2. The date the entity first reported to the DLG annual receipts from all sources or annual expenditures equal to or greater than \$100,000 but less than \$500,000.

(c) A special purpose governmental entity required by KRS 65A.030(1)(c)(2) to contract for the provision of an annual audit shall ensure that it receives an audit no more than one (1) year from the date it last reported to the DLG annual receipts from all sources or annual expenditures equal to or greater than \$500,000.

(3) Each submission shall be submitted to the DLG Web site as a portable document format (PDF) file.

(4) Except as provided in subsection (5) of this section, an audit shall be conducted on a modified cash basis of accounting as described in this subsection.

(a) Revenues shall be recognized when received.

(b) Expenditures shall be recognized when paid.

(c) Capital assets and long-term debt shall be reported when material to the special purpose governmental entity.

(d) Note disclosures shall include all those required by generally accepted accounting principles to the extent those disclosures apply to the special purpose governmental entity under the modified cash basis of accounting described in this subsection.

(e) Cash and other liquid assets available that are held in reserve for future purposes shall be disclosed.

(5) As an alternative to the minimum requirements established in subsection (3) of this section, an audit may be conducted under generally accepted accounting principles.

Section 6. Payment of the Registration Fee. (1) Each special purpose governmental entity shall pay the annual registration fee required by KRS 65A.020(5) within fifteen (15) days after the start of each fiscal period.

(a) The amount paid by each special purpose governmental entity shall be based on annual revenues of the special purpose governmental entity. For each fiscal period for which a registration fee is due, if the annual revenue information has not been submitted to the DLG as required by Section 4(3) of this administrative regulation, the annual revenues on which the registration fee shall be based shall be the annual revenues reported as part of the initial registration of the special purpose governmental entity pursuant to KRS 65A.090.

(b) Payment shall be made electronically, using the information reporting portal on the DLG Web site, at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm> unless permission to pay by an alternative method has been granted under subsections (2) and (3) of this section.

(c) Payment shall be accompanied by a completed DLG Form SPGE 101.

(2) A special purpose governmental entity may request permission to pay the registration fee by alternative means by submitting a written request that includes the following information at least thirty (30) days before the payment is due:

(a) The name of the special purpose governmental entity;

(b) A statement of the reason why the payment cannot be submitted using the standard electronic submission format; and

(c) The method of payment proposed.

(3)(a) Approval of an alternative method of payment shall be at the discretion of the DLG. If the DLG approves an alternative payment method, the special purpose governmental entity shall submit the payment in the form and format determined by the DLG and communicated to the special purpose governmental entity as part of the approval process.

(b) The DLG may withdraw approval to use an alternative payment method at any time by providing written notice of the withdrawal of approval to the special purpose governmental entity at least thirty (30) days prior to the effective date of the withdrawal of approval.

Section 7. Failure to File Required Information or to Pay the Annual Registration Fee in a Timely Manner. Any special purpose governmental entity that fails to file a report or form in the form and format and within the timeframes required by this administrative regulation, or that fails to submit payment of the annual registration fee as required by this administrative regulation, shall be subject to the provisions of KRS 65A.040.

Section 8. Incorporation by Reference. (1) The following regulation is incorporated by reference:

(a) DLG Form SPGE 100, "Special Purpose Governmental Entity (SPGE) Registration and Board Reporting Form", September 2013; and

(b) DLG Form SPGE 101, "Special Purpose Governmental Entity (SPGE) Financial Disclosure Report", September 2013.

(2) This material may be inspected, copied, or obtained,

subject to applicable copyright law, at the Department for Local Government, 1024 Capital Center Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or online at <https://kydlgweb.ky.gov/Entities/SpecDistHome.cfm>.

TONY WILDER, Commissioner

APPROVED BY AGENCY: December 6, 2013

FILED WITH LRC: December 18, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Tuesday, February 25, 2014 at 10:00 a.m. at the Department for Local Government, 1024 Capital Center Drive, 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 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 11:59 p.m. on February 28, 2014. 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: Darren T. Sammons, Staff Attorney, Department for Local Government, 1024 Capital Center Drive, Suite 341, Frankfort, Kentucky 40601, phone (502) 573-2382, fax (502) 573-2939.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Darren T. Sammons

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation prescribes and adopts the standard forms, protocols, timeframes, and due dates for the submission of information by special purpose governmental entities. This administrative regulation establishes the format for financial disclosure by special purpose governmental entities and prescribes the protocols, timeframes, and due dates for submission of information by special purpose governmental entities.

(b) The necessity of this administrative regulation: This administrative regulation is necessary for DLG to satisfy the requirements of KRS Chapter 65A.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms closely to the content of KRS Chapter 65A by establishing the manner in which special purpose governmental entities will register with DLG and submit the administrative and financial information required by statute. This administrative regulation imposes no additional requirements beyond those set forth by the statute or which DLG concludes are required by implication or otherwise are necessary for the statute to be effective.

(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 statute primarily by setting forth the mechanism by which special purpose governmental entities will report administrative and financial information and by prescribing the method by which such entities will pay the statutory fees.

(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: Not applicable.

(b) The necessity of the amendment to this administrative regulation: Not applicable.

(c) How the amendment conforms to the content of the authorizing statutes: Not applicable.

(d) How the amendment will assist in the effective administration of the statutes: Not applicable.

(3) List the type and number of individuals, businesses,

organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects entities that meet the definition of Special Purpose Governmental Entities as defined by KRS 65A.010. At present, DLG is aware of 1,272 entities that meet the statutory definition.

(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 regulated entities will have to file administrative and financial information with the Department for Local Government and will have to pay the statutory filing fee.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each entity will have to pay twenty-five (25) dollars, \$250 or \$500, as required by KRS 65A.020(5)(b).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): The financial information for each special purpose governmental entity will be reported and published in an electronic format that will be accessible to all members of the public. Such greater transparency may increase public confidence in special purpose governmental entities.

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

(a) Initially: \$63,700, which has been provided as a Necessary Governmental Expense ("NGE").

(b) On a continuing basis: The statutory fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) years.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Funding has been provided as a Necessary Governmental Expense ("NGE") by the General Assembly.

(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 will be necessary to implement the administrative regulation. The fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) years.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This regulation does not establish any fees, however, it does specify the method for payment of the fees that were established by KRS 65A.020(5)(b).

(9) TIERING: Is tiering applied? The fees were established by KRS 65A.020(5)(b), which applies tiering as follows: "Special Purpose Governmental Entities with an annual revenue from all sources of less than \$100,000, twenty-five (25) dollars;" "Special Purpose Governmental Entities with an annual revenue from all sources of at least \$100,000 but less than \$500,000, \$250;" and "Special Purpose Governmental Entities with an annual revenues of \$500,000 or greater, \$500."

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 Special Purpose Governmental Entities, as defined by KRS 65A.010(8), will be impacted by this regulation.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 65A.020, 65A.030, 65A.040, and 65A.090

(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 will have no effect on the expenditures and revenues of any state or local government agency. However, there may be an effect from the authorizing statute (KRS Chapter 65A).

(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 any state or local government agency. However, there may be revenue from the authorizing statute (KRS Chapter 65A), but any revenue is expected to cover the expense of the program itself.

(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 any state or local government agency. However, there may be revenue from the authorizing statute (KRS Chapter 65A), but any revenue is expected to cover the expense of the program itself.

(c) How much will it cost to administer this program for the first year? This program will cost an estimated \$63,700.

(d) How much will it cost to administer this program for subsequent years? The statutory fees were calculated to provide adequate funding to implement the administrative regulation and its authorizing statute (KRS Chapter 65A). It is anticipated that the fees will remain sufficient for a minimum of two (2) 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: No additional expenditures are necessary to implement this administrative regulation.

GENERAL GOVERNMENT CABINET Kentucky Board of Barbering (Repealer)

201 KAR 14:052. Repeal of 201 KAR 14:051, 201 KAR 14:080, and 201 KAR 14:170.

RELATES TO: KRS 317.440

STATUTORY AUTHORITY: KRS 317.440

NECESSITY, FUNCTION, AND CONFORMITY: The statutory authority for apprentices was repealed in 2013, thus obviating the need for 201 KAR 14:051 and 201 KAR 14:080. As a matter of good policy, 201 KAR 14:170 should be repealed because there are some instances when a reinstatement should not be permitted.

Section 1. The following administrative regulations are hereby repealed:

- (1) 201 KAR 14:051, Supervision of apprentice licensees;
- (2) 201 KAR 14:080, Number of apprentices per shop; and
- (3) 201 KAR 14:170, Reinstatement in case of revocation of license.

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014, at 10:00 a.m. (EST) at 9114 Leesgate Road, Suite 6, Louisville, Kentucky 40222-5055. Individuals interested in being heard at this hearing shall notify this agency in writing by February 17, 2014, five working days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. This hearing is open to the public. Any person who wishes to be heard shall be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written

comments shall be accepted until February 28, 2014. 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: Francis L. Simpson, Board Chair, Kentucky Board of Barbering, 9114 Leesgate Road Suite 6, Louisville, Kentucky 40222, phone (502) 429-7148, fax (502) 429-7149.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Francis Simpson

(1) Provide a brief summary of:

(a) What this administrative regulation does: Repeals three regulations that aren't required anymore due to a statute change in 2013.

(b) The necessity of this administrative regulation: 201 KAR 14:052 repeals regulations because of statute changes that made these regulations unnecessary.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The three regulations that are being repealed are due to a statute change in 2013 that removed the requirement of an apprenticeship from our law.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It removes unneeded language from our regulations.

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

(a) How the amendment will change this existing administrative regulation: The repealed regulations remove references to apprentices.

(b) The necessity of the amendment to this administrative regulation: It is necessary for the Kentucky Board of Barbering to repeal three regulations that are no longer needed because of a change in statutes in 2013.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to promulgate administrative regulations as established by KRS 317.440.

(d) How the amendment will assist in the effective administration of the statutes: It will remove three regulations from our law that are no longer authorized by statute.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Around 1,100 barber shops, nine (9) barber schools, 3,000 barbers and 111 probationary barbers.

(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: These regulations will be repealed, thus, eliminating apprenticeships.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): \$0

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Apprenticeships will no longer be necessary.

(5) Provide an estimate of how much it will cost to implement this administrative regulation: \$0

(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: There will be no cost 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 will be necessary to implement this administrative regulation.

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

This administrative regulation does not establish any fees nor does it increase any fees either directly or indirectly.

(9) TIERING: Is tiering applied? No, the repealers apply to all licensees.

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 will impact the Kentucky Board of Barbering.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: KRS 317.440.

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. \$0

(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? \$0

(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? \$0

(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 (+/-): \$0

Expenditures (+/-): \$0

Other Explanation: No revenues will be generated or expended.

GENERAL GOVERNMENT CABINET Board of Nursing (New Administrative Regulation)

201 KAR 20:405. Delegation of the administration of insulin and glucagon in a school setting.

RELATES TO: KRS 314.011, 156.501, 156.502, 158.838

STATUTORY AUTHORITY: KRS 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.011(6) authorizes registered nurses to delegate to unlicensed persons. This administrative regulation establishes standards for the delegation of the administration of insulin or glucagon in school settings.

Section 1. Definitions. (1) "Delegatee" means a person to whom a nursing task is delegated.

(2) "Delegator" means a registered nurse who delegates a nursing task to an unlicensed person.

(3) "Diabetes medical management plan" means a written order signed by a physician or an advanced practice registered nurse (APRN) which is valid only for the current school year and which contains the following information:

(a) Student's name;

(b) Directions for determining the prescribed type and dosage of insulin based on blood glucose level, carbohydrate intake, and other appropriate factors; (c) the route of administration of insulin;

(d) The frequency that the insulin may be administered;

(e) Whether the student may self-administer insulin;

(f) Whether the student's diabetes care may be delegated; and

(g) The emergency care plan.

(4) "Emergency care plan" means the plan of care to address and treat hypoglycemia and hyperglycemia including what to do in an emergency based on the medical order.

(5) "Examination" means a written test on the content of the

KBN Insulin Administration in School Settings Training Program and a skills validation check-off.

Section 2. Insulin Administration. (1)(a) The administration of insulin may be delegated by the delegator in the school setting, which includes all school sponsored programs, in accordance with the requirements of this section.

(b) The delegator shall make the decision to delegate knowingly and only in those situations where the delegator or another nurse is not available.

(c) This administrative regulation shall not preclude a child from self-administration of insulin.

(2) The administration of insulin shall not be delegated unless:

(a) A parent or guardian of the child has provided a copy of the current diabetes medical management plan;

(b) A parent or guardian of the child authorizes in writing the administration of insulin; and

(c) The delegatee has successfully completed the KBN Insulin Administration in School Settings Training Program.

(3)(a) The diabetes medical management plan and authorization described in subsections (2)(a) and (2)(b) of this section shall be valid for the current school year. The most current diabetes medical management plan shall be provided by a parent or guardian to the delegator. A current diabetes medical management plan and authorization shall be provided by a parent or guardian at the beginning of each school year, when changes occur, or if there is a transfer of schools.

(b) A registered nurse shall not delegate the administration of insulin without a current diabetes medical management plan.

(c) A copy of the current diabetes medical management plan or authorization shall be maintained by the delegator and the delegatee.

(4) Insulin administration by the delegatee shall only occur:

(a) Following successful completion of the KBN Insulin Administration in School Settings Training Program; and

(b) When the delegatee has followed the diabetes medical management plan and any instructions from the delegator.

(5) The delegatee may administer insulin through use of an insulin pen or an insulin pump only. Insulin delivery by any other method shall be administered by a nurse.

(6) When an emergency care plan must be implemented, the delegatee may consult with either the delegator, the prescribing physician, or APRN, as the situation warrants. A parent or guardian shall be notified following the event.

(7) The delegator may delegate to the delegatee the counting of carbohydrates or other tasks necessary for the determination of an insulin dose. These tasks shall be performed in accordance with the diabetes medical management plan. The delegatee shall verify the carbohydrate count and the subsequent insulin dose with the delegator, unless the delegator decides the verification is unnecessary.

(8) If the diabetes medical management plan states that the child is capable of self-administration, the delegator may delegate to the delegatee the verification of insulin dosage via a pen, a pump, or an injection.

(9) The delegator shall supervise the delegatee in the administration of insulin in accordance with 201 KAR 20:400, Section 4. If the delegator determines that the delegator's physical presence is not required, the delegator shall be available by telephone or other electronic means to the delegatee to answer questions, provide instruction, and verify the carbohydrate count and the subsequent insulin dose.

Section 3. Glucagon administration. (1) Glucagon shall be administered in accordance with KRS 158.838.

(2) Instruction on glucagon administration shall be included in the KBN Insulin Administration in School Settings Training Program.

Section 4. Training. (1) The delegatee shall successfully complete the KBN Insulin Administration in School Settings Training Program.

(2) The KBN Insulin Administration in School Settings Training

Program shall be taught by a registered nurse, an APRN, or a physician who has completed the KBN Insulin Administration in School Settings Training Program before teaching unlicensed school personnel.

(3)(a) The KBN Insulin Administration in School Settings Training Program shall be conducted initially over a period of at least four (4) hours which shall include an examination.

(b) The minimum passing score on the content portion of the examination shall be eighty-five (85) percent.

(c) The minimum passing score on the skills validation portion of the examination shall be 100 percent.

(d) The delegatee may repeat either the content portion of the examination or the skills validation portion of the examination one time if needed. If unable to be successful, the delegatee shall repeat the training, but not more than three times.

(4)(a) The person conducting the training shall issue a certificate of completion when the delegatee has completed the training and has demonstrated competence in the tasks to be delegated.

(b) A copy of the certificate of completion shall be maintained by the parties for at least two years and shall be presented to the delegatee and to the delegator, if a different person than the trainer.

(c) The trainer shall maintain a roster of all participants and their completion scores for at least five (5) years.

(5) The delegatee shall complete a refresher course based on the KBN Insulin Administration in School Settings Training Program including the examination each school year. The content of the refresher course shall be determined by the delegator.

(6) A parent or guardian may attend the KBN Insulin Administration in School Settings Training Program.

Section 5. The delegator may rescind the delegation if, in the opinion of the delegator, the student's safety is in jeopardy.

Section 6. Implementation. Trainers and delegates shall complete the KBN Insulin Administration in School Settings Training Program prior to the beginning of the 2014 school year.

Section 7. Incorporation by Reference. (1) "KBN Insulin Administration in School Settings Training Program", 2013 Edition, Kentucky Board of Nursing, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, Monday through Friday, 8:00 a.m. to 4:30 p.m.

SALLY BAXTER, President

APPROVED BY AGENCY: December 13, 2013

FILED WITH LRC: January 15, 2014 at 9 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 26, 2014 at 10:00 a.m. (EST) in the office of the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by February 19, 2014, five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Nathan Goldman, General Counsel, Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, phone (502) 429-3309, fax (502) 564-4251, email nathan.goldman@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Nathan Goldman

(1) Provide a brief summary of:

(a) What this administrative regulation does: It permits nurses to delegate the administration of insulin and glucagon to unlicensed school personnel for students with diabetes.

(b) The necessity of this administrative regulation: Some students with diabetes are unable to administer insulin on their own. Unfortunately, there are insufficient numbers of school nurses in Kentucky. This regulation provides for the training of unlicensed school personnel and allows a nurse to delegate the administration to that person.

(c) How this administrative regulation conforms to the content of the authorizing statutes: By setting standards and requirements.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By setting standards and requirements.

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

(a) How the amendment will change this existing administrative regulation:

(b) The necessity of the amendment to this administrative regulation:

(c) How the amendment conforms to the content of the authorizing statutes:

(d) How the amendment will assist in the effective administration of the statutes:

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: students with diabetes, number unknown.

(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: School nurses will be able to delegate the administration of insulin to trained unlicensed school personnel for students with diabetes.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each school will be required to provide training for the unlicensed school personnel, cost unknown.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): They will be able to receive insulin injections from unlicensed school personnel.

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

(a) Initially: There is no additional cost.

(b) On a continuing basis: There is no additional cost.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Agency 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 is needed.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: It does not.

(9) TIERING: Is tiering applied? Tiering was not applied as the changes apply to all equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Board of Nursing, the Kentucky Department of Education, and school districts.

(2) Identify each state or federal statute or federal regulation

that requires or authorizes the action taken by the administrative regulation. KRS 314.131.

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? 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? Unknown.

(d) How much will it cost to administer this program for subsequent years? Unknown.

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:

**TRANSPORTATION CABINET
Department of Highways
Division of Maintenance
(New Administrative Regulation)**

603 KAR 10:001. Definitions.

RELATES TO: KRS 177.830-177.890, 177.572-177.576, 23 U.S.C. 103, 23 U.S.C. 131, 23 C.F.R. Part 750

STATUTORY AUTHORITY: KRS 177.860, 23 U.S.C. 131

NECESSITY, FUNCTION, AND CONFORMITY: KRS 177.860 requires the cabinet to promulgate administrative regulations to establish reasonable standards for advertising devices on or visible from interstate, parkway, and federal-aid primary highways. This administrative regulation defines the terms used in 603 KAR Chapter 10.

Section 1. Definitions. The following definitions shall apply in this chapter:

(1) "Abandoned" or "discontinued" means that for a period of one (1) year or more a static advertising device as used in 603 KAR 10:010 or an electronic advertising device as used in 603 KAR 10:020 has:

(a) Not displayed advertising matter;

(b) Displayed obsolete advertising matter; or

(c) Needed substantial repairs due to lack of maintenance.

A notice that the device is for sale, rent, or lease shall not be considered advertising matter.

(2) "Activity boundary line" means the delineation on a property of those regularly used buildings, parking lots, storage, and process areas that are an integral part of and essential to the primary business activity that takes place on the property.

(3) "Advertising device" is defined by KRS 177.830(5).

(4) "Cabinet" means the Kentucky Transportation Cabinet.

(5) "Centerline of the highway" means a line equidistant from the edges of the median separating the main-traveled ways of a divided interstate, parkway, national highway system, or federal-aid primary highway, or the centerline of the main-traveled way of a nondivided interstate, parkway, national highway system, or federal-aid primary highway.

(6) "Certified arborist" means an arborist prequalified within the landscaping classification of the Transportation Cabinet's Prequalification Committee and is certified by the Kentucky Arborists Association as a certified arborist or a board certified master arborist.

(7) "Cleaning" means selective pruning to remove only dead or broken branches.

(8) "Commercial or industrial activities" is defined by KRS 177.830(9).

(9) "Commercial or industrial business" means a business engaging in a commercial or industrial enterprise.

(10) "Commercial or industrial developed area" means an area on:

(a) An interstate or parkway where at least seven (7) commercial or industrial businesses are located within an off-premise protected area; and

(b) A national highway system or federal-aid primary highway where a commercial or industrial zone, or unzoned commercial or industrial area is located.

(11) "Commercial or industrial enterprise" means an activity on an interstate or parkway carried on for financial gain and generally recognized as commercial or industrial by local zoning authorities. The following shall not be considered a commercial or industrial enterprise:

(a) An outdoor advertising structure;

(b) An agricultural, forestry, ranching, grazing, farming, and related enterprise, including a wayside fresh produce stand;

(c) An enterprise normally or regularly in operation less than three (3) months of the year;

(d) A transient or temporary enterprise;

(e) An enterprise not visible from the main traveled way;

(f) An enterprise conducted in a building principally used as a residence;

(g) A railroad track and minor siding;

(h) A facility generally recognized as a utility;

(i) A church or cemetery;

(j) A parking or storage lot; or

(k) A hospital or school.

(12) "Commercial or industrial zone" is defined by KRS 177.830(7).

(13) "Crown" means the leaves and branches of a tree measured from the lowest branch on the trunk to the top of the tree.

(14) "Crown Elevation or Raising" means the removal of lower tree limbs to allow clearance or visibility beneath the crown while maintaining the natural symmetry of the tree.

(15) "Department" means the Department of Highways within the Kentucky Transportation Cabinet.

(16) "Destroyed" means a static advertising device as used in 603 KAR 10:010 or an electronic advertising device as used in 603 KAR 10:020 requiring repair due to weather related events, vandalism, or other criminal or torturous acts.

(17) "Electronic advertising device" means an advertising device with a message that is changed by an electronic process or remote control, including rotating cubes, rotating vertical triangular slats, turning lights on and off, glow cubes, light emitting diodes, cathode ray tubes and florescent discharge or other similar technology approved by the cabinet.

(18) "Erect" means to construct, build, raise, assemble, place, affix, attach, create, paint, draw, or bring into being or establish. It shall not mean the change of a message or routine maintenance.

(19) "Extension" means an addition to a static advertising device in excess of the static advertising device's face.

(20) "Face" means the part of the static advertising device with a uniform length and uniform height, including trim and background that contains the two (2) dimensional message and informative content.

(21) "Facing" means all faces displayed on the same static advertising device as established in 603 KAR 10:010 or the same electronic advertising device as established in 603 KAR 10:020 and oriented in the same direction of travel.

(22) "Federal-aid primary highway" is defined by KRS 177.830(3) and 23 U.S.C. 131 and shown by the Transportation Cabinet on <http://maps.kytc.ky.gov/PAFOA/>.

(23) "Highway" means:

(a) For purposes of 603 KAR 10:010 and 603 KAR 10:020, an interstate, parkway, national highway system, or federal-aid primary highway shown by the Transportation Cabinet on <http://maps.kytc.ky.gov/PAFOA/>; and

(b) For purposes of 603 KAR 10:030, a public road maintained

by the department.

(24) "Illegal" means an advertising device located in a protected area that is in violation of 603 KAR 10:010 or 603 KAR 10:020.

(25) "Interstate" is defined by KRS 177.830(2) and 23 U.S.C. 103 and shown by the Transportation Cabinet on <http://maps.kytc.ky.gov/PAFOA/>.

(26) "Main traveled way" means the traveled way of a highway on which through traffic is carried. This shall not include such facilities as frontage roads, turning roadways, or parking areas.

(27) "National highway system" is defined by 23 U.S.C. 103 and shown by the Transportation Cabinet on <http://maps.kytc.ky.gov/PAFOA/>.

(28) "Non-billboard off-premise electronic advertising device" means an electronic advertising device located on a federal-aid primary highway or a national highway system highway that is not located on the property that it is advertising and is limited to advertising for a city, church, or civic club located within the community in which the electronic advertising device is erected.

(29) "Non-billboard off-premise static advertising device" means a static advertising device located on a federal-aid primary highway or a national highway system highway that is not located on the property that it is advertising and is limited to advertising for a city, church, or civic club located within the community in which the static advertising device is erected. "Civic or community advertising device" may be used interchangeably with "non-billboard off-premise static advertising device."

(30) "Non-conforming electronic advertising device" means an off-premise electronic advertising device that was lawfully erected but:

(a) Does not comply with a subsequent state law or administrative regulation; or

(b) Does not comply with a changed condition that may include the following:

1. Zoning change;

2. Highway relocation or reclassification;

3. Change in a restriction on size, space, or distance; or

4. Abandonment of required business or businesses.

(31) "Non-conforming static advertising device" means an off-premise static advertising device that was lawfully erected but:

(a) Does not comply with a subsequent state law or administrative regulation; or

(b) Does not comply with a changed condition that may include the following:

1. Zoning change;

2. Highway relocation or reclassification;

3. Change in a restriction on size, space, or distance; or

4. Abandonment of required business or businesses.

(32) "Obsolete" means an advertisement that is out-of-date by thirty (30) days or more, or is no longer discernible.

(33) "Official sign" means a sign located within the highway right-of-way that has been installed by or on behalf of the department or another public agency having jurisdiction that meets one of the following purposes:

(a) To denote the location of underground utilities;

(b) A requirement by a federal, state, or local government to delineate the boundaries of a reservation, park, or district;

(c) To identify a street or highway;

(d) To control traffic; or

(e) A requirement by state law.

(34) "Off-premise advertising device" means an off-premise electronic advertising device and an off-premise static advertising device.

(35) "Off-premise electronic advertising device" means an electronic advertising device that contains a message relating to an activity or product that is foreign to the site on which the electronic advertising device and message are located or an electronic advertising device erected by a company or individual for the purpose of selling advertising messages for rental income.

(36) "Off-premise protected area" means an area upon or within 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway.

(37) "Off-premise static advertising device" means a static

advertising device that contains a message relating to an activity or product that is foreign to the site on which the static advertising device and message are located, or a static advertising device erected by a company or individual for the purpose of selling advertising messages for rental income.

(38) "On-premise advertising device" means an on-premise electronic advertising device and an on-premise static advertising device.

(39) "On-premise electronic advertising device" means an electronic advertising device that consists solely of the name of the establishment or that identifies the establishment's principal, or accessory products or services offered on the property. It does not mean an electronic advertising device that brings rental income to the property owner.

(40) "On-premise protected area" means an area:

(a) Upon or within 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway both in and outside of an urban area; and

(b) Outside of an urban area and beyond 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway.

(41) "On-premise static advertising device" means a static advertising device that consists solely of the name of the establishment or that identifies the establishment's principal, or accessory products or services offered on the property. It does not mean a static advertising device that brings rental income to the property owner.

(42) "Parkway" means as formally designated by the Transportation Cabinet on <http://maps.kytc.ky.gov/PAFOA/>.

(43) "Permitted" means authorized to exist only if a permit is issued from the Department of Highways.

(44) "Protected area" means:

(a) For a static advertising device, an off-premise protected area and an on-premise protected area; and

(b) For an electronic advertising device, an urbanized protected area and an on-premise protected area.

(45) "Pruning" or "prune" means the selective removal of plant parts without damaging the natural symmetry of the tree or without having a negative effect on the tree's long-term health and is restricted to cleaning, crown elevation, raising, and thinning.

(46) "Routine maintenance" on a nonconforming static advertising device as used in 603 KAR 10:010 or a nonconforming electronic advertising device as used in 603 KAR 10:020 or on a scenic highway means:

(a) In kind replacement of material components with a like material component;

(b) Painting of supports and frames;

(c) Changing of an advertising message;

(d) Changing existing nonstructural external light fixtures for energy efficiency;

(e) Replacement of nuts, bolts, or nails;

(f) A safety related addition that does not increase the structural integrity of the static advertising device or the electronic advertising device;

(g) A safety related addition that does not prolong the life of the static advertising device or the electronic advertising device; and

(h) Rebuilding of a destroyed static advertising device or electronic advertising device.

(47) "Scenic byway" is defined by KRS 177.572.

(48) "Scenic highway" is defined by KRS 177.572.

(49) "Scenic strip or site" means an area of particular scenic beauty or historic significance as determined by a federal, state, or local governmental agency having jurisdiction of the area and includes an interest in land that has been acquired for the restoration, preservation and enhancement of scenic beauty.

(50) "Sign Viewing Zone" means an area as established in Figure One incorporated by reference in 603 KAR 10:030 that measures 500 feet maximum along the adjacent edge of the nearest travel lane on the same side of the highway on which the sign is permitted, that has:

(a) As terminus A, the point on the adjacent edge of travel lane immediately opposite the edge of the outdoor advertising sign face closest to the highway at a ninety (90) degree angle to the

highway;

(b) As terminus B, the point measured along the edge of pavement 500 feet maximum in the direction from which the sign is viewed; provided that Terminus B shall not include areas within an interchange except along the outside shoulders of the outermost ramps and parallel to a state right of way; and

(c) As terminus C, the point on the edge of the sign that is furthest from the highway.

(51) "Static advertising device" means an advertising device that does not use electric or mechanical technology to change the message.

(52) "Target Viewing Zone" means an area as established in Figure One incorporated by reference in 603 KAR 10:030 that is a combined area of up to 250 feet horizontal distance parallel to a state right-of-way and within the sign viewing zone in which trees, except dogwoods, redbuds, or the official state tree may be removed or pruned with a view permit.

(53) "Thinning" or "thin" means work consisting of selective pruning to reduce density of live branches that results in an even distribution of branches on individual limbs and throughout the crown.

(54) "Topping" or "top" means the reduction of a tree's size using heading cuts that shorten limbs or branches back to a predetermined crown limit, to sever the leader or leaders, or to prune a tree by the stubbing of mature wood.

(55) "Tree abuse" means:

(a) Topping, cutting, or other acts performed to a tree that destroys a tree's natural habit;

(b) Pruning that leaves stubs or results in a flush cut or splitting of limb ends including chemical or mechanical shearing or mowing of trees;

(c) The use of equipment that will damage the bark including climbing spikes, nails or hooks, except for the purpose of total tree removal; or

(d) Damaging a tree while felling another tree.

(56) "Turning roadway" means a connecting roadway for traffic turning between two intersecting lanes of an interchange.

(57) "Unzoned commercial or industrial area" is defined by KRS 177.830(8).

(58) "Urban area" is defined by KRS 177.830(10).

(59) "Urbanized protected area" means an area upon or within 660 feet of the right-of-way of an interstate, parkway, National Highway System, or federal-aid primary highway with a population of fifty 50,000 or more as demonstrated by the United States Department of Commerce, United States Census Bureau.

(60) "View permit" means a permit issued by the department to the owner of an advertising device to remove or prune vegetation on the state's right-of-way.

(61) "Visible" means:

(a) A message or any part of the static advertising device structure capable of being seen, whether or not legible, without visual aid by a person of normal visual acuity on a scenic highway; or

(b) A message capable of being seen, whether or not legible, without visual aid by a person of normal visual acuity in a protected area not on a scenic highway.

NANCY ALBRIGHT, Deputy State Highway Engineer

MIKE HANCOCK, Secretary

APPROVED BY AGENCY: January 15, 2014

FILED WITH LRC: January 15, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 24, 2014 at 10:00 a.m. local time at the Transportation Cabinet, Transportation Cabinet Building, Hearing Room C121, 200 Mero Street, Frankfort, Kentucky 40622. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If you have a disability for which the Transportation Cabinet needs to provide accommodations, please notify us of your requirement five working days prior to the hearing. This request does not have to be in writing. 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 wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: D. Ann D'Angelo, Asst. General Counsel, Transportation Cabinet, Office of Legal Services, 200 Mero Street, Frankfort, Kentucky 40622, phone (502) 564-7650, fax (502) 564-5238.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Ann D'Angelo

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation contains all definitions previously contained in 603 KAR 3:080 and adds new definitions applicable to static, electronic, and vegetation regulations for advertising devices in Kentucky.

(b) The necessity of this administrative regulation: This regulation is necessary to inform the public of the requirements for permitting, operating and maintaining billboards.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 177.860 requires the cabinet to promulgate administrative regulations prescribing standards for the erection, maintenance and operation of advertising devices and 23 U.S.C. 131 conditions retention of additional federal funding on the establishment of controls over the placement of outdoor advertising devices.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will clarify and provide definitions related to billboard permitting in Kentucky.

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

(a) How the amendment will change this existing administrative regulation: N/A

(b) The necessity of the amendment to this administrative regulation: N/A

(c) How the amendment conforms to the content of the authorizing statutes: N/A

(d) How the amendment will assist in the effective administration of the statutes: N/A

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects persons and corporations wishing to erect, operate, and maintain billboards.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: This new regulation contains definitions applicable to the permitting process in 603 KAR Chapter 10.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This new administrative regulation contains only definitions applicable to the erection, operation, and maintenance of advertising devices.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This administrative regulation contains definitions applicable to the erection, operation, and maintenance of advertising devices.

(5) Provide an estimate of how much it will cost the administrative body to implement the administrative regulation: There are no known costs associated with the amendments to this

administrative regulation.

(a) Initially:

(b) On a continuing basis:

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

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

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No fees are established by this regulation either directly or indirectly.

(9) TIERING: Is tiering applied? No. Tiering is not applied because this administrative regulation addresses only definitions.

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 Cabinet's Department of Highways, Division of Maintenance.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 176.860 and 23 U.S.C. 131.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. There will not be any effect on the expenditures of a state or local agency.

(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 additional 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 additional revenue.

(c) How much will it cost to administer this program for the first year? No administrative costs are required or expected.

(d) How much will it cost to administer this program for subsequent years? No subsequent administrative costs are anticipated.

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:

TRANSPORTATION CABINET Department of Highways Division of Maintenance (New Administrative Regulation)

603 KAR 10:020. Electronic advertising devices.

RELATES TO: KRS 177.572-177.576, 177.830-177.890, 177.990(2)

STATUTORY AUTHORITY: KRS 177.860, 23 U.S.C. 131

NECESSITY, FUNCTION, AND CONFORMITY: KRS 177.860 requires the cabinet to promulgate administrative regulations establishing standards for advertising devices. KRS 177.890 authorizes the Commissioner of Highways to enter into agreements with the United States Secretary of Transportation in order to carry out national policy relating to interstate, defense, and federal-aid primary highways within the state. Compliance with the "Highway Beautification Act", 23 U.S.C. 131, conditions retention of additional federal funding on the establishment of controls over the

placement of outdoor advertising devices. This administrative regulation establishes the standards for on-premise and off-premise electronic advertising devices.

Section 1. General Conditions Relating to Electronic Advertising Devices. (1) The requirements of this section shall apply to an electronic advertising device visible from an interstate, parkway, national highway system, or federal-aid primary highway.

(2) An off-premise electronic advertising device upon or within 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway shall be prohibited unless the device:

(a) Is not visible from the interstate, parkway, national highway system, or federal-aid primary highway; or
(b) Meets the following:

1. Complies with county or city zoning ordinances and regulations;
2. Is located in a commercial or industrial developed area;
3. Is located in an urbanized protected area; and
4. Complies with this administrative regulation.

(3) An on-premise electronic advertising device that complies with this administrative regulation may be erected:

(a) Upon or within 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway both in and outside of an urban area; or

(b) Outside of an urban area and beyond 660 feet of the right-of-way of an interstate, parkway, national highway system, or federal-aid primary highway; and

(c) If the device complies with this administrative regulation.

(4) An electronic advertising device that is visible from more than one (1) interstate, parkway, national highway system, or federal-aid primary highway shall meet the requirements for each highway independently.

(5) The erection or existence of an electronic advertising device shall be prohibited in a protected area if the device:

- (a) Advertises an activity that is prohibited by law;
- (b) Is abandoned or discontinued;
- (c) Is not clean, safe, and in good repair;
- (d) Is not securely affixed to a substantial structure permanently attached to the ground;
- (e) Directs the movement of traffic;
- (f) Interferes with, imitates, or resembles an official traffic sign, signal, or traffic control device;
- (g). Prevents the driver of a vehicle from having a clear and unobstructed view of an official sign or approaching or merging traffic;

- (h) Is erected or maintained upon a tree;
- (i) Is erected upon or overhanging the right-of-way;
- (j) Has a face larger than 450 square feet;
- (k) Has more than one (1) face per facing; or
- (l) Is a nonbillboard off-premise electronic advertising device.

(6) The following criteria shall apply to an off-premise electronic advertising device located in an urbanized protected area.

(a) An off-premise electronic advertising device shall not be erected:

1. If visible from an on-ramp;
2. Within 500 feet of a lane reduction;
3. Within 500 feet of an at-grade intersection;
4. Within 2,500 feet of a scenic strip or site;
5. Where vegetation has been removed by permit from right-of-way within ten (10) years and within 1,000 feet of the proposed electronic advertising device; or
6. In a high vehicular accident area as determined by the cabinet and supported by a traffic engineering study.

(b) An on-premise static or on-premise electronic advertising device shall not affect spacing requirements for an off-premise electronic advertising device.

(c) An off-premise electronic advertising device shall not contain extensions to the face.

(d) The name of the owner of an off-premise electronic advertising device shall be legible from the main traveled way and shall not be larger than twenty (20) square feet. The owner's name

shall be shown without other owner information and shall not be considered a message.

(e) The maximum height of an off-premise electronic advertising device shall be fifty (50) feet from the ground surface to the top of the structure.

(f) To establish an urbanized protected area, the distance from the edge of a state-owned right-of-way shall be measured horizontally and at a right angle to the centerline of the interstate, parkway, national highway system, or federal-aid primary highway for a distance of 660 feet.

(g) The message on an off-premise electronic advertising device shall:

1. Be static for at least eight (8) seconds;
2. Change from one message to another in less than two (2) seconds;
3. Not exceed a luminance of 250 nits during daylight hours or 100 nits during nighttime hours;
4. Not blink, scroll, or contain animation or video; and
5. Be programmed to freeze in a static display if a malfunction occurs.

(h) An off-premise electronic advertising device shall not consume electricity from an external source.

(7) The following criteria shall apply to a nonconforming off-premise electronic advertising device located in a protected area.

(a) A non-conforming electronic advertising device may continue to exist if:

1. Not abandoned or discontinued;
2. Subjected to only routine maintenance;
3. In compliance with state law and administrative regulations, as well as local zoning, sign, or building restrictions at the time of the erection; and
4. The device including its structure remains substantially the same as it was on the effective date of the state law or administrative regulation that made the device nonconforming.

(b) The owner of a non-conforming electronic advertising device shall submit biennial updates on a completed Advertising Device Biennial Certification Form, TC Form 99-206.

(c) An incomplete or inaccurate submission shall not be considered an update submittal.

(d) The update submittal for a non-conforming advertising device shall be submitted electronically to the department pursuant to the following table:

Dept.of Highway's District #	Submittal Year	Submittal Period*
1 & 7	Odd	January 1- April 30th
2 & 4	Even	January 1- April 30th
3 & 9	Odd	May 1st- August 31st
6 & 8	Even	May 1st- August 31st
5 & 11	Odd	September 1st – December 31st
10 & 12	Even	September 1st – December 31st

* A submittal shall be received during the submittal period to be considered.

(e) Failure to submit an update by the deadline outlined above shall subject the owner of the non-conforming electronic advertising device to action pursuant to Section 5 of this administrative regulation.

(f) The following shall be considered non-routine maintenance to a non-conforming electronic advertising device:

1. Extension or enlargement of the device;
2. Replacement, rebuilding, or re-erection of a device that has not been destroyed;
3. A change in the structural support including material diameters, dimensions, or type that would result in an increased economic life such as replacement of wood posts with steel posts or the replacement of a wood frame with a steel frame;
4. The addition of bracing, guy wires, or other reinforcement;
5. A change in the location of the structure; or
6. A change in the direction of the face.

(g) Performance of nonroutine maintenance on a

nonconforming electronic advertising device shall constitute a violation of this administrative regulation and action shall be taken pursuant to Section 5 of this administrative regulation.

(8) The following criteria shall apply to an on-premise electronic advertising device located in an on-premise protected area.

(a) An on-premise electronic advertising device shall not exceed 450 square feet if it is placed within fifty (50) feet of the activity boundary line.

(b) If further than fifty (50) feet from the activity boundary line, an on-premise electronic advertising device shall not exceed:

1. Twenty (20) feet in length, width, or height; or
2. 150 square feet in area, including border and trim and excluding supports.

(c) An on-premise electronic advertising device shall be located on the property and within 400 feet from the activity boundary line.

(d) No more than one (1) on-premise electronic advertising device or one (1) on-premise static advertising device shall be located at a distance greater than fifty (50) feet from the activity boundary line.

(e) If taking measurements for the placement of an on-premise electronic advertising device for an industrial park, the service road shall be considered within the activity boundary line for the industrial park.

(f) An on-premise electronic advertising device erected to advertise one (1) of the businesses in a shopping center, mall, or other combined business location shall not be located more than fifty (50) feet from the activity boundary line of the business being advertised.

(g) If taking measurements for the placement of a single on-premise electronic advertising device for a shopping center, mall, or other combined business location, the combined parking area shall be considered within the activity boundary line.

(h) A single on-premise electronic advertising device erected for a shopping center, mall, or other combined business location may:

1. Identify each of the individual businesses conducted at the location; or
2. Include a single display area used to advertise on-premise activities.

(i) The following shall apply to the message on an on-premise electronic advertising device:

1. Electronic advertising device display features and functions are permitted, except for flashing and full motion video or film display via an electronic file imported into the electronic advertising device software or streamed in real time into the electronic advertising device which are prohibited.

2. The message shall not exceed a luminance of 250 nits during daylight hours or 100 nits during nighttime hours.

3. A single message or segment of a message shall have a display time of at least two (2) seconds including the time needed to move the message onto the electronic advertising device, with all segments of the total message to be displayed within eight (8) seconds.

4. A message consisting of one (1) segment may remain on the electronic advertising device for an amount of time in excess of two (2) seconds.

5. An electronic advertising device message requiring more than four (4) seconds to change from one (1) single message to another shall be turned off during the change interval.

6. A display traveling horizontally across the electronic advertising device shall move between sixteen (16) and thirty-two (32) light columns per second.

7. A display may scroll onto the electronic advertising device but shall hold for two (2) seconds including the scrolling time.

Section 2. Electronic Advertising Devices on Interstates and Parkways. (1) The requirements of this section shall apply to an electronic advertising device visible from an interstate or parkway.

(2) If visible from the main traveled way or turning roadway of an interstate or parkway and meets the permitting criteria established in this administrative regulation, an off-premise

electronic advertising device located in an urbanized protected area of an interstate or parkway shall be permitted by the department.

(3) No permit shall be issued unless an off-premise electronic advertising device:

(a) Complies with Section 1 and this section of this administrative regulation;

(b) Is erected or maintained in an urbanized protected area of an interstate or parkway;

(c) Complies with KRS 177.830 through 177.890, this administrative regulation, and county or city zoning ordinances and regulations;

(d) Is erected or maintained in a commercial or industrial developed area:

1. The commercial or industrial developed area shall contain at least seven (7) commercial or industrial businesses.

2. The commercial or industrial business structures shall be:

a. Separated by no more than 1,600 feet measured from the activity boundary line of the business pursuant to subsection (8) of this section;

b. Equipped with water and electricity;

c. Open to the public with regular business hours or regularly used by the employees as their principal work station; and

d. In operation at the current location for no less than twelve (12) months prior to permit application submittal.

3. The area shall be within an incorporated municipality as the boundaries existed on September 21, 1959.

(e) Is no closer than fifty (50) feet to the edge of the main traveled way or turning roadway of the interstate or parkway; and

(f) Replaces six (6) off-premise advertising devices as established in subsection (4) of this section.

(4)(a) Six (6) off-premise advertising devices located in a protected area shall be removed prior to receiving a permit and prior to erecting an electronic advertising device.

(b) A permittee shall receive a conditional permit until the six (6) off-premise advertising devices are removed pursuant to paragraph (a) of this subsection.

(c) The six (6) off-premise advertising devices to be removed shall be identified in the permit application.

(d) If the permittee does not own six (6) off-premise advertising devices, the devices shall be obtained in order to comply with this subsection. In special cases, upon written petition and for good cause shown, the commissioner of highways may permit deviations from this paragraph.

(e) The off-premise advertising devices removed pursuant to paragraph (a) of this subsection shall be:

1. Approved by the department for removal; and

2. Nonconforming or illegal off-premise static or electronic devices located on an interstate or parkway; or

3. Legal, illegal, or nonconforming static or electronic advertising devices visible from a scenic highway.

(5) If one (1) or more of the seven (7) businesses required by subsection (3) of this section is terminated or no longer exists, the off-premise electronic advertising device may be reclassified as a non-conforming electronic advertising device pursuant to Section 5 of this administrative regulation.

(6) An off-premise electronic advertising device visible from an interstate or parkway shall not be erected within 2,500 feet of another off-premise electronic advertising device.

(7) An off-premise electronic advertising device visible from an interstate or parkway shall not be erected within 1,500 feet of an off-premise static advertising device on either side of the interstate or parkway.

(8) To measure distances for the identification of a commercial or industrial developed area:

(a) Lines shall be drawn perpendicular to the center line of the interstate or parkway, extending from each side of the interstate or parkway.

(b) The first perpendicular line shall be drawn from the activity boundary line of the first-encountered commercial or industrial business.

(c) The last perpendicular line shall be drawn from the activity boundary line of the last-encountered commercial or industrial

business.

(d) The distance between the activity boundary line of the first and last encountered commercial or industrial business shall not exceed 1,600 feet.

(e) Each perpendicular line shall extend for a distance of 660 feet from each edge of the right-of-way of the interstate or parkway.

(f) Area within the confines of the lines perpendicular to the center line of the interstate or parkway shall be considered if establishing a commercial and industrial developed area.

(g) The electronic advertising device shall be on the same side of the interstate or parkway where at least four (4) of the commercial or industrial businesses are located and within 100 feet of the activity boundary line of one of the four (4) businesses.

(h) A business on either side of the interstate or parkway within the confines of the lines perpendicular to the centerline of the interstate or parkway may be counted as part of the seven (7) required businesses.

Section 3. Electronic Advertising Devices on National Highway System and Federal-Aid Primary Highways. (1) The requirements of this section shall apply to an electronic advertising device visible from a national highway system or federal-aid primary highway.

(2) If visible from the main traveled way or turning roadway of a national highway system or federal-aid primary highway and meets the permitting criteria established in this administrative regulation, an off-premise electronic advertising device shall be permitted by the department.

(3) An off-premise electronic advertising device is prohibited in a protected area of a national highway system or federal-aid primary highway if:

(a) Prohibited by KRS 177.863(1);

(b) Within 2,500 feet of an official picnic area, golf course, public park, recreational area, forest preserve, church, school, battlefield, rest area, museum, historical monument, state park, national park; or

(c) Within 2,500 feet of a scenic strip or site.

(4) A permit shall not be issued unless an off-premise electronic advertising device meets the following criteria:

(a) Complies with Section 1 and this section of this administrative regulation;

(b) Is erected and maintained in an urbanized protected area of a national highway system or federal-aid primary highway:

1. In a commercial or industrial zone; or

2. In an unzoned commercial or industrial area with a commercial or industrial activity that is located on the same side of the highway and within 700 feet of the off-premise electronic advertising device as established in subsection (6) of this section;

(c) Complies with KRS 177.830 through 177.890, this administrative regulation, and county or city zoning ordinances; and

(d) Replaces six (6) advertising devices pursuant to subsection (5) of this section.

(5)(a) Six (6) off-premise advertising devices located in a protected area shall be removed prior to receiving a permit and prior to erecting an electronic advertising device.

(b) A permittee shall receive a conditional permit until the six (6)

(d) If the permittee does not own six (6) off-premise advertising devices, the devices shall be obtained in order to comply with this subsection. In special cases, upon written petition and for good cause shown, the commissioner of highways may permit deviations from this paragraph.

(e) The off-premise advertising devices removed pursuant to paragraph (a) of this subsection shall be:

1. Approved by the department for removal; and

2. Nonconforming or illegal off-premise static or electronic advertising devices located on a national highway or a federal-aid highway; or

3. Legal, illegal, or nonconforming static or electronic advertising devices visible from a scenic highway.

(6) To measure the correct distance for an off-premise electronic advertising device from a commercial or industrial activity:

(a) Two (2) lines shall be drawn from the activity boundary line perpendicular to the centerline of the main traveled way to encompass the greatest longitudinal distance along the center line of the national highway system or federal-aid primary highway.

(b) Measurements shall begin at the outside edge of the activity boundary lines and shall be measured 700 feet in each direction.

(7) Spacing per visible direction of travel between electronic off-premise advertising devices shall be 2,500 feet.

Section 4. Required Permits, Renewals, and Transfers. (1) The requirements of this section shall apply to electronic advertising devices on an interstate, parkway, national highway system, or federal-aid primary highway.

(2) A permit shall be required from the department for an off-premise electronic advertising device located in an urbanized protected area.

(3) An initial permit shall be valid until the expiration of the applicable renewal period. If the renewal period falls within six (6) months of the initial permit issuance, the initial permit shall be good until the next renewal period.

(4) An application for an off-premise electronic advertising device permit shall be made on a completed Application for Off-Premise Advertising Device, TC Form 99-31.

(5) The issuance of an off-premise electronic advertising device permit relevant to spacing between off-premise static or electronic advertising devices shall be determined on a "first-come, first-served" basis.

(6) A permittee shall submit a biennial renewal to the department. A renewal shall be made on a completed Advertising Device Biennial Certification Form, TC Form 99-206. An incomplete or inaccurate submission shall not be considered.

(7)(a) If submitting a biennial renewal, the permittee shall certify that the off-premise electronic advertising device meets the permit requirements of this administrative regulation.

(b) If an off-premise electronic advertising device no longer meets the permit requirements of this administrative regulation, the permittee may request a conditional renewal in order to become compliant with the permit requirements.

(c) If the permittee fails to become compliant, the permit shall not be renewed and the off-premise advertising device shall be reclassified as a non-conforming electronic advertising device.

(8) A renewal submittal for an electronic advertising device shall be submitted electronically to the department pursuant to the following schedule:

Dept. of Highway's District #	Submittal Year	Submittal Period*
1 & 7	Odd	January 1- April 30th
2 & 4	Even	January 1- April 30th
3 & 9	Odd	May 1st- August 31st
6 & 8	Even	May 1st- August 31st
5 & 11	Odd	September 1st – December 31st
10 & 12	Even	September 1st – December 31st

* A submittal shall be received during the submittal period to be considered.

(9) Failure to submit a renewal by the deadline outlined in subsection (8) of this section shall result in the off-premise advertising device being designated as illegal and action shall be taken pursuant to Section 5 of this administrative regulation.

(10) An electronic advertising device may be sold, leased, or otherwise transferred without affecting its status, but its location shall not be changed. A transfer of ownership for an electronic advertising device shall be submitted on a completed Advertising Device Ownership Transfer, TC Form 99-205.

(11) An application amendment for a substantial change to an approved off-premise electronic advertising device permit shall be submitted and approved by the department prior to work being performed.

(12) An off-premise electronic advertising device that has been permitted but not constructed shall not be installed if the permitted location becomes ineligible prior to installation. If the location is no

longer permissible the permit shall be canceled.

(13) An on-premise electronic advertising device shall be in compliance with the provisions of this administrative regulation but shall not require a permit.

Section 5. Notice of Violations; Appeals. (1) The department shall notify the owner of the electronic advertising device by certified letter that the device is in violation of KRS Chapter 177 or this administrative regulation.

(2) The owner of the device shall be given thirty (30) days to respond to the violations outlined in the department's notice.

(3) If the owner fails to respond to the certified notice or fails to remedy the violations within thirty (30) days, the electronic advertising device shall be converted to a static face and the department may proceed to take legal action.

(4) If the owner receives a certified notice for a nonconforming off-premise electronic device and fails to respond or remedy the violations within thirty (30) days, the device shall lose its non-conforming status.

(5)(a) An owner aggrieved by the findings of the department may request an administrative hearing in writing within twenty (20) days of the notice.

(b) A request for a hearing shall thoroughly detail the grounds upon which the hearing is requested.

(c) The hearing request shall be addressed to the Transportation Cabinet, Office of Legal Services, 200 Mero Street, Frankfort, Kentucky 40622. The administrative hearing shall be conducted pursuant to KRS Chapter 13B.

Section 6. Scenic Highways and Byways. (1) After designation of a scenic highway by the Transportation Cabinet, no additional off-premise electronic advertising devices shall be erected, allowed, or permitted that are visible from the scenic highway.

(2) The sponsor of a scenic byway application may petition the Transportation Cabinet to impose the same regulations for electronic advertising devices located on scenic byways as those located on scenic highways.

(3) Only routine maintenance shall be performed on an off-premise electronic advertising device legally in existence on the date of the scenic highway designation.

Section 7. Penalties. (1) The owner of an electronic advertising device who willfully violates a provision of this administrative regulation shall be assessed a penalty of \$500 per day, per violation, per message pursuant to KRS 177.990(2).

(2) The department shall deny or revoke a permit if the application contains false or materially misleading information.

(3) The department shall deny the owner of an off-premise electronic advertising device erected without a permit an electronic advertising permit for up to fifteen (15) years.

Section 8. Incorporated by Reference. (1) The following material is incorporated by reference:

(a) "Agreement for Carrying Out National Policy Relative to Control of Outdoor Advertising in Areas Adjacent to the National System of Interstate and Defense Highways and the Federal-Aid Primary System;

(b) "Application for Off Premise Advertising Device", TC 99-31, May, 2013;

(c) "Advertising Device Biennial Certification Form", TC 99-206, December, 2013;

(d) "Advertising Device Ownership Transfer", TC-205, December, 2013; and

(e) The formal designation of interstates, parkways, national highway system, and federal aid primary highways by the Transportation Cabinet on the cabinet's Web site at: <http://maps.kytc.ky.gov/PAFOA/>.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Transportation Cabinet Building, Department of Highways, 200 Mero Street, Frankfort, Kentucky 40622, Monday through Friday, 8 a.m. to 4:30 p.m.

(3) This material is also available on the cabinet's Web site at <http://transportation.ky.gov/Construction/Pages/Kentucky->

[Standard-Specifications.aspx](#).

NANCY ALBRIGHT, Deputy State Highway Engineer
MIKE HANCOCK, Secretary

APPROVED BY AGENCY: January 15, 2014

FILED WITH LRC: January 15, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 26, 2014 at 10:00 a.m. local time at the Transportation Cabinet, Transportation Cabinet Building, Hearing Room C121, 200 Mero Street, Frankfort, Kentucky 40622. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If you have a disability for which the Transportation Cabinet needs to provide accommodations, please notify us of your requirement five working days prior to the hearing. This request does not have to be in writing. 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 wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: D. Ann D'Angelo, Asst. General Counsel, Transportation Cabinet, Office of Legal Services, 200 Mero Street, Frankfort, Kentucky 40622, phone (502) 564-7650, fax (502) 564-5238.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Ann D'Angelo

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes standards for the erection of outdoor electronic advertising devices.

(b) The necessity of this administrative regulation: This regulation is necessary to ensure conformity in the erection of electronic advertising devices.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 177.860 requires the cabinet to promulgate administrative regulations to set reasonable standards for advertising devices. 23 U.S.C. 131 ("The Highway Beautification Act") requires the state to maintain effective control over outdoor advertising devices or risk losing its apportionment of federal aid highway funds.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will establish the procedures involved in permitting and maintenance of electronic advertising devices.

(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: N/A

(c) How the amendment conforms to the content of the authorizing statutes: N/A

(d) How the amendment will assist in the effective administration of the statutes: N/A

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This new administrative regulation affects persons wishing to erect outdoor electronic advertising devices.

(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: Persons wishing to erect an outdoor electronic advertising device will have to file an application for a permit.

(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 fees involved with this administrative regulation. However, this regulation permits the erection of electronic billboards and allows a potential permittee to "swap" a number of non-conforming billboards in exchange for permitting a new, off-premise electronic advertising device on interstates and parkways (where allowed by federal law) and NHS and FAP highways.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): These requirements insure conformity in the erection of electronic advertising devices.

(5) Provide an estimate of how much it will cost the administrative body to implement the administrative regulation: There are no known costs associated with the amendments to this administrative regulation.

(a) Initially:

(b) On a continuing basis:

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

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

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No fees are established by this regulation either directly or indirectly.

(9) TIERING: Is tiering applied? No. Tiering is not applied. All persons wishing to erect an electronic advertising device will have to apply for a permit.

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 Cabinet's Department of Highways, Division of Maintenance.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 176.860 and 23 U.S.C. 131.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. There will not be any effect on the expenditures of a state or local agency.

(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 additional 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 additional revenue.

(c) How much will it cost to administer this program for the first year? No funding increase to implement the administrative regulation will be required.

(d) How much will it cost to administer this program for subsequent years? No subsequent administrative costs are anticipated.

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 containing the federal mandate. 23 U.S.C. 131 and the Bonus Agreement entered into by the Federal Highway Administration (FHWA) and the Kentucky Department of Highways.

2. State compliance standards. Outdoor advertising devices are controlled on interstates, parkways, national highway system, and federal-aid primary highways. Erection of new outdoor advertising devices adjacent to or visible from a scenic highway are prohibited.

3. Minimum or uniform standards contained in the federal mandate. Outdoor advertising devices are to be controlled on interstates, parkways, national highway system, and federal-aid primary highways. No new outdoor advertising devices are allowed on scenic highways.

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

5. Justification for the imposition of the stricter standard or additional or different responsibilities or requirements. In 1961, Kentucky entered into a Bonus Agreement with FHWA. Per the agreement, Kentucky placed stricter controls on outdoor advertising devices in exchange for approximately \$2.5 million in federal bonus payments. Violation of the agreement could cause those funds to be repaid to the federal government.

TRANSPORTATION CABINET Department of Highways Division of Maintenance (New Administrative Regulation)

603 KAR 10:030. Removal of vegetation related to advertising devices.

RELATES TO: KRS 177.830-177.890, 177.990(2), 23 U.S.C. 131, 23 C.F.R. Part 750

STATUTORY AUTHORITY: KRS 177.860, 23 U.S.C. 131

NECESSITY, FUNCTION, AND CONFORMITY: KRS 177.860 requires the cabinet to promulgate administrative regulations establishing standards for advertising devices. This administrative regulation establishes a permitting process by which the owner of an advertising device may apply for a permit to remove vegetation blocking the view of an advertising device.

Section 1. View Permit Application and Eligibility. (1) The owner of an advertising device that is visible from a highway may apply to the department for a view permit to remove or prune vegetation that is growing on the state right-of-way to improve the view of an advertising device.

(2) The following advertising devices may be eligible for a view permit:

(a) An off-premise advertising device located in a protected area that has been in existence for five (5) years or more that meets the requirements of subsection (5) of this section;

(b) An advertising device not located in a protected area that has been in existence for five (5) years or more; and

(c) An on-premise advertising device if the vegetation management does not affect the sign viewing zone of an off-premise advertising device.

(3) A view permit shall not be issued:

(a) For a nonconforming, abandoned, or illegal off-premise advertising device located in a protected area;

(b) For an advertising device visible from a scenic highway;

(c) If the four (4) off-premise advertising devices have not been approved and removed as required pursuant to subsection (5) of this section;

(d) If the applicant, including subsidiaries, has three (3) view permits with work that has not been completed;

(e) For work proposed within medians, interchange quadrants, or within interchange areas, except along the outside shoulders of the outermost ramps;

(f) Where the applicant proposes to access the advertising device over state owned right-of-way;

(g) Where the vegetation to be pruned or removed is part of a beautification project implemented prior to the view permit application; or

(h) If the applicant does not comply with this administrative regulation.

(4) The submitted application for a view permit shall include:

(a) A completed Application for Outdoor Advertising Device View Permit, TC Form 99-208;

(b) The address and telephone number of the owner of the advertising device;

(c) A photograph, location map, and scaled drawing showing the location of the advertising device, the sign viewing zone, and target viewing zone;

(d) A vegetation management plan submitted by a certified arborist that shall include:

1. A general description of vegetation in the sign viewing zone;

2. An inventory of trees larger than three (3) inches in diameter measuring six (6) inches from the ground surface individually, and trees that are proposed to be pruned or otherwise impacted shall be noted; and

3. A general description of work to be performed in the sign viewing zone;

(e) Proof that the applicant has obtained local, state, or federal approval where required;

(f) The name and address of the contractor that will be performing the work;

(g) A signed release from contiguous property owners allowing the applicant to perform the requested vegetation removal or pruning;

(h) A seeding and erosion control plan pursuant to the department's manual, Standard Specifications for Road and Bridge Construction;

(i) If not provided per paragraph (e) of this subsection, a letter or permit stating the local governing body, including local tree boards where established, does not object to the view permit;

(j) The location of off-premise advertising devices proposed to be removed by the applicant if necessary to meet the requirements of subsection (5) of this section;

(k) The proposed work schedule;

(l) A performance bond;

(m) Proof of liability insurance equal to or in excess of \$3 million. The department shall be listed as the "Certificate Holder;"

(n) Consent from a private property owner that gives the owner of the advertising device access from the private property to the work site; and

(o) A work zone plan.

(5)(a) Four (4) off-premise advertising devices located in a protected area shall be removed prior to receiving a view permit for an off-premise advertising device that is eligible as established in subsection (2)(a) of this section.

(b) The permittee shall receive a conditional permit until the four (4) off-premise advertising devices are removed pursuant to paragraph (a) of this subsection.

(c) If the permittee does not own four (4) off-premise advertising devices, the devices shall be obtained in order to comply with this subsection. In special cases, upon written petition and for good cause shown, the commissioner of highways may permit deviations from this paragraph.

(d) The off-premise advertising devices to be removed shall be:

1. Approved by the department for removal; and

2. Non-conforming or illegal off-premise static or electronic advertising devices located on the same highway type as the view permit; or

3. Legal, illegal, or nonconforming static or electronic advertising devices visible from a scenic highway.

(6) An application shall be submitted electronically.

(7) This administrative regulation shall not be construed to permit an activity that conflicts with a law, regulation, or agreement at the federal, state, or local level.

not be allowed to:

(a) Remove more than twenty-five percent (25) percent of the crown of each tree;

(b) Remove vegetation with a diameter of three (3) inches or more measuring six (6) inches from the ground surface;

(c) Thin or selectively prune a tree part greater than one-and-a-half (1 1/2) inches in diameter;

(d) Access the sign viewing zone from the adjacent highway utilizing state right-of-way. Access to the sign viewing zone shall only be obtained from private property owners;

(e) Alter the target viewing zone for the life of the advertising device;

(f) Remove or prune vegetation without the supervision of a certified arborist; or

(g) Remove a redbud, dogwood, or the state tree.

(2) Work performed pursuant to a view permit shall be performed within 180 consecutive calendar days of the work start date.

(3) If the view permit allows for the removal of a tree, the following restrictions shall apply:

(a) Tree stumps and roots on a slope of 3:1 or less that project through or appear on the ground surface shall be removed by cutting or grinding flush with the surrounding ground surface.

(b) A hole or void created by the removal or grinding of stumps shall be filled, graded, and compacted with acceptable fill material.

(c) Tree stumps and roots on a slope greater than 3:1 shall be removed to a height of three (3) inches or less above the surrounding ground. Stump height shall be measured from the top of the stump to the base of the stump on the lowest side of the slope.

(d) A tree stump may be treated with a selective herbicide if approved by the department. The herbicide shall have an approved dye for inspection purposes and shall be applied within fifteen (15) minutes after cutting.

(4) The work performed pursuant to a view permit shall include proper disposal of waste and debris related to vegetation management within fourteen (14) calendar days from the first cutting activity.

(5) Work shall not be performed on right-of-way until an approved view permit is received from the department.

(6)(a) Removal and pruning of vegetation under a view permit shall be supervised by a certified arborist.

(b) The certified arborist shall notify the department that the work has been completed and certify that the work was performed according to the view permit.

(c) The department shall review the work and notify the view permit holder if corrective work is necessary.

(d) Two (2) years after the work has been completed, the permittee shall submit to the department a certified report completed by a certified arborist that includes a minimum of six (6) color photographs from different vantage points that demonstrate the entire group of trees within the sign viewing zone are healthy.

Section 3. Notice of Violation; Appeals. (1) The department shall notify the view permit holder by certified letter if it determines a violation of KRS Chapter 177 or this administrative regulation has occurred.

(2) The view permit holder shall have thirty (30) days to respond to the violations outlined in the department's notice.

(3) If the view permit holder fails to respond to the certified notice or fails to remedy the violations within thirty (30) days, the department may proceed to take legal action against the permit holder.

(4)(a) A view permit holder aggrieved by the findings of the department may request an administrative hearing in writing within twenty (20) days of the notice.

(b) A request for a hearing shall thoroughly detail the grounds on which the hearing is requested.

(c) The hearing request shall be addressed to the Transportation Cabinet, Office of Legal Services, 200 Mero Street, Frankfort, Kentucky 40622. The administrative hearing shall be conducted pursuant to KRS Chapter 13B.

Section 2. View Permit Restrictions. (1) A view permittee shall

Section 4. Penalties. (1) A view permit holder who willfully violates this administrative regulation shall be fined \$500 per inch of diameter of each tree in accordance with KRS 177.990(2).

(2) The department shall deny or revoke a view permit that contains false or materially misleading information.

(3) Work performed by the certified arborist found to be inaccurate or misleading shall be grounds for the arborist's removal from the department's prequalified list.

(4) Vegetation removal performed for an advertising device without a view permit or work performed that is a material deviation from the view permit shall be grounds for:

(a) Denial of a future vegetation permit application by the view permit holder for up to fifteen (15) years; and

(b) Revocation of the advertising device permit upon which the vegetation removal was performed.

(5) If a tree dies within two (2) years of being pruned pursuant to a view permit, the permittee shall:

(a) Be fined in accordance with subsection (1) of this section;

(b) Repay the cabinet for the state-owned tree; and

(c) Replant the area to the satisfaction of the cabinet.

(6) If tree abuse, death, or a violation occurs to trees not included in the view permit, the view permit holder shall be fined in accordance with subsection (1) of this section and shall be required to replant the area to the satisfaction of the department or, at the discretion of the department, replant another area.

(7) The permittee shall be solely responsible for damage or destruction to private property that occurs in the course of executing the vegetation management plan.

(8) The permittee shall agree to indemnify the department and the cabinet in the event that claims are brought against it by third parties for damages sustained in the course of executing the vegetation management plan.

Section 5. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Application for Outdoor Advertising Device View Permit", TC 99-208, January, 2014; and

(b) "Standard Specifications for Road and Bridge Construction", June 15, 2012.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Transportation Cabinet, Department of Highways, 200 Mero Street, Frankfort, Kentucky 40622.

(3) This material is also available on the cabinet's Web site at <http://transportation.ky.gov/Construction/Pages/Kentucky-Standard-Specifications.aspx>.

NANCY ALBRIGHT, Deputy State Highway Engineer
MIKE HANCOCK, Secretary

APPROVED BY AGENCY: January 15, 2014

FILED WITH LRC: January 15, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on February 27, 2014 at 10:00 a.m. local time at the Transportation Cabinet, Transportation Cabinet Building, Hearing Room C121, 200 Mero Street, Frankfort, Kentucky 40622. Individuals interested in being heard at this hearing shall notify this agency in writing five (5) working days prior to the hearing, of their intent to attend. If you have a disability for which the Transportation Cabinet needs to provide accommodations, please notify us of your requirement five working days prior to the hearing. This request does not have to be in writing. 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 wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until February 28, 2014. 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: D. Ann D'Angelo, Asst. General Counsel,

Transportation Cabinet, Office of Legal Services, 200 Mero Street, Frankfort, Kentucky 40622, phone (502) 564-7650, fax (502) 564-5238.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Ann D'Angelo

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes requirements for the owner of a permitted advertising device to apply for and obtain a permit to selectively remove vegetation to improve the viewing of the advertising device.

(b) The necessity of this administrative regulation: This regulation is necessary to control the removal of vegetation in and around Kentucky's interstates, parkways, NHS and FAP highways.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 177.860 requires the Cabinet to promulgate reasonable standards for the erection and maintenance of advertising devices.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will specify the requirements for obtaining a view permit for existing advertising devices.

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

(a) How the amendment will change this existing administrative regulation: N/A

(b) The necessity of the amendment to this administrative regulation: N/A

(c) How the amendment conforms to the content of the authorizing statutes: N/A

(d) How the amendment will assist in the effective administration of the statutes: N/A

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects persons wishing to selectively prune existing vegetation to permit a better view of an advertising device.

(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 owner of an advertising device will have to apply for and obtain a view permit application prior to selectively removing or pruning trees.

(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 fees involved with this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): These requirements will permit the owners of advertising devices to selectively remove some vegetation that obstructs the travelling public's view of the device.

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

(a) Initially: Approximately \$345,000

(b) On a continuing basis: Approximately \$345,000

(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: There is no need for the cabinet to increase fees or funding.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No fees are established by this regulation either directly or indirectly.

(9) TIERING: Is tiering applied? No. Tiering is not applied. All advertising device owners who wish to apply for a view permit must

do so.

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 Cabinet's Department of Highways, Division of Maintenance.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS176.860 and 23 U.S.C. 131.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. There will not be any effect on the expenditures of a state or local agency.

(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 additional 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 additional revenue.

(c) How much will it cost to administer this program for the first year? Approximately \$345,000.

(d) How much will it cost to administer this program for subsequent years? Approximately \$345,000.

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

Revenues (+-):

Expenditures (+-):

Other Explanation:

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

900 KAR 10:100. Appeals of Eligibility Determinations for KHBE Participation and Insurance Affordability Programs.

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 appeals of eligibility determinations for KHBE participation and insurance affordability programs in accordance with 42 U.S.C. 18031 and 45 C.F.R. parts 155 and 156.

Section 1. Definitions. (1) "Advanced payment of premium tax credits" or "APTC" means payment of the tax credits authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through an exchange in accordance with section 1412 of the Affordable Care Act.

(2) "Adverse witness" means a person who gives unfavorable evidence against the party that called him or her as its witness.

(3) "Agency head" means the secretary of the Cabinet for Health and Family Services.

(4) "Appeal record" means the official record of hearing as defined by KRS 13B.130(1) through (10).

(5) "Appeal request" means a clear expression, either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have an eligibility determination or redetermination contained in a notice issued in accordance with 45 C.F.R. 155.310(g) or 45 C.F.R. 330(e)(1)(ii).

(6) "Appellant" means the applicant or enrollee who is requesting an appeal.

(7) "Applicant" means an individual who is seeking eligibility for himself or herself through an application submitted to the KHBE for at least one (1) of the following:

(a) Enrollment in a QHP through the KHBE; or

(b) Medicaid and KCHIP, if applicable.

(8) "Authorized representative" means:

(a) For an enrollee or applicant who is authorized by Kentucky law to provide written consent, an individual or entity acting on behalf of, and with written consent from, the enrollee or applicant; or

(b) A legal guardian.

(9) "Cost-sharing reduction" or "CSR" means a reduction in cost sharing for an eligible individual enrolled in a silver level plan in an exchange or for an individual who is an Indian enrolled in a qualified health plan in an exchange.

(10) "DAH" means the Division of Administrative Hearings of the Cabinet for Health and Family Services.

(11) "DCBS" means the Department for Community Based Services.

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

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

(14) "Exemption" means an exemption from the shared responsibility payment.

(15) "Final order" is defined by KRS 13B.010(6).

(16) "Hearing" is defined by KRS 13B.010(2).

(17) "Hearing officer" means a hearing officer employed by DAH.

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

(19) "Judicial review" means a court's review of factual or legal findings of an administrative body.

(20) "Kentucky Children's Health Insurance Program" or "KCHIP" means the separate child health program established by the Commonwealth of Kentucky under title XXI of the Social Security Act in accordance with implementing regulations at 42 C.F.R. 457.

(21) "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-based health insurance marketplace that includes an:

(a) Individual exchange; and

(b) Small Business Health Options Program.

(22) "MAGI-based income" is defined by 42 C.F.R. 435.603(e).

(23) "Personally identifiable information" means any data about an individual that could potentially identify that individual.

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

(25) "Recommended order" is defined by KRS 13B.010(5).

(26) "Tax filer" is defined by 45 C.F.R. 155.300.

(27) "Vacate" means to set aside a previous action.

Section 2. Right to Appeal an Individual Eligibility Determination or Redetermination. (1) An applicant or an enrollee shall have the right to make an appeal request of:

(a) An eligibility determination made in accordance with 45 C.F.R. 155, subpart D and 900 KAR 10:030, including:

1. An initial determination of eligibility for enrollment in a QHP, including the amount of APTC and CSR, made in accordance with the standards specified in 45 C.F.R. 155.305(a) through (h); or

2. A redetermination of eligibility, including the amount of APTC and CSR, made in accordance with 45 C.F.R. 155.330 and

155.335;

(b) A failure by the KHBE to provide timely notice of an eligibility determination pursuant to 45 C.F.R. 155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii) or 156.610(i);

(c) A denial of a request to vacate dismissal made by DAH in accordance with 45 C.F.R. 155.530(d)(2), made pursuant to Section 9(3) of this administrative regulation; or

(d) An eligibility determination for an exemption made in accordance with 45 C.F.R. 155.605.

(2) Upon exhaustion of the appeal process established in this administrative regulation, an appellant shall have the right to:

(a) Appeal to HHS according to regulations adopted by the secretary of HHS; and

(b) Seek a judicial review of an appeal decision pursuant to KRS 13B.140.

(3) The state Medicaid agency shall retain authority for an appeal of a Medicaid or a KCHIP MAGI-based income determination of eligibility.

(4) The DAH shall conduct an appeal of an individual eligibility determination, except for an eligibility determination for an exemption made in accordance with 45 C.F.R. 155.605.

(5) An appeal of an eligibility determination of an exemption shall be conducted by HHS.

Section 3. Designation of a Representative. (1) An appellant may represent himself or herself or be represented during an appeal process by:

(a) Legal counsel;

(b) An authorized representative as set forth in 900 KAR 10:030;

(c) A relative;

(d) A friend; or

(e) Another individual not listed in paragraph (a), (b), (c), or (d) of this subsection.

(2) KHBE shall designate a representative to act on behalf of the KHBE for the hearing.

Section 4. Notice of Appeal Rights. (1) An applicant or an enrollee shall be notified of a right to appeal at the time:

(a) The applicant submits an application; and

(b) A notice of eligibility determination is sent by KHBE under 45 C.F.R. 155.310(g), 155.330(e)(1)(ii), or by HHS under 45 C.F.R. 155.610(i).

(2) A notice described in subsection (1) of this section shall include:

(a) An explanation of the applicant or enrollee's appeal rights in accordance with this administrative regulation;

(b) A description of the procedure to request an appeal;

(c) Information on the applicant or enrollee's right to represent himself or herself or to be represented by legal counsel or other authorized person;

(d) An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision in accordance with Section 8 of this administrative regulation; and

(e) An explanation that an appeal decision for one (1) household member may result in a:

1. Change in eligibility for another household members; or

2. Redetermination of eligibility in accordance with 900 KAR 10:030.

Section 5. Appeal Requests. (1) An applicant or an enrollee may submit an appeal request:

(a) By phone by contacting the kynect contact center;

(b) By mail to the KHBE;

(c) In person at a local DCBS office; or

(d) Via the internet at Kynect.ky.gov.

(2) Upon request, the KHBE or the DAH shall assist an applicant or enrollee in filing an appeal.

(3) An applicant or enrollee's right to appeal shall not be limited or interfered with by an employee or agent of the KHBE.

(4) An applicant or enrollee shall have thirty (30) days from the date of notice of an eligibility determination or redetermination to

submit an appeal request.

(5) The date of notice shall be five (5) calendar days after the date on the notice unless an applicant or enrollee can show that the notice was not received within the five (5) day period.

Section 6. Informal Resolution. (1) After receiving an appeal request, the Office of the Kentucky Health Benefit Exchange shall:

(a) Conduct a desk review of an appeal prior to sending the appeal to the DAH; and

(b) Complete the review within ten (10) days of receipt of the appeal request.

(2) The desk review shall consider information submitted during the application process and any supporting documentation used to determine an appellant's eligibility.

(3) An appellant shall:

(a) Have the right to a hearing if the appellant is dissatisfied with the outcome of the informal resolution process; and

(b) Not have to provide duplicative information or documentation previously provided during the application.

(4) The outcome of an informal resolution shall be final and binding and the appeal shall not advance to a hearing if the appellant:

(a) Is satisfied with the outcome of the informal resolution process; and

(b) Withdraws his or her appeal request in accordance with Section 12 of this administrative regulation.

Section 7. Acknowledgement of Appeal Request and Eligibility Record. (1) A request for an appeal shall be sent to the DAH no later than ten (10) days of receipt of the appeal request.

(2) A request for an appeal shall be reviewed by DAH to ensure that the appeal request is valid.

(3) Upon receipt of a valid appeal request, the DAH shall:

(a) Send timely notice to the appellant of receipt of the valid appeal request by certified mail, return receipt requested, to include:

1. Information regarding the appellant's eligibility pending appeal in accordance with Section 8 of this administrative regulation;

2. An explanation that any APTCs paid on behalf of a tax filer pending appeal are subject to reconciliation under 26 C.F.R. 1.36B-4; and

3. The hearing requirements contained in Section 10 of this administrative regulation;

(b) Send timely notice of the appeal request to the KHBE and, if applicable, instructions to provide eligibility pending appeal pursuant to Section 8 of this administrative regulation; and

(c) Confirm receipt of the records transferred by KHBE pursuant to subsection (5) of this section.

(4) The DAH shall consider an appeal request valid that was incorrectly delivered or mailed to a department or division of the Cabinet for Health and Family Services but is otherwise valid.

(5) Upon receipt of an appeal request that is not valid, the DAH shall:

(a) Send written notice to the appellant that the appeal request has not been accepted and of the nature of the defect in the appeal request; and

(b) Accept an amended appeal request as valid that meets the requirements of this administrative regulation.

(6) Upon receipt of a notice under subsection (2)(b) of this section, the KHBE shall submit the appellant's eligibility record to the DAH.

Section 8. Eligibility Pending Appeal. (1) An appellant who has submitted a valid appeal of a redetermination of eligibility in accordance with Section 5 of this administrative regulation shall be considered eligible while the appeal is pending.

(2) If a tax filer or appellant accepts eligibility pending an appeal of an eligibility redetermination, the appellant's eligibility for an APTC or CSR or enrollment in a QHP as applicable shall be continued in accordance with the level of eligibility immediately before the redetermination being appealed.

(3) An appellant may waive receipt of APTCs pending the

outcome of an appeal.

(4) The continued receipt of APTCs during an appeal may impact the amount owed or due by an appellant during the reconciliation set forth in 26 C.F.R. 1.36B-4, depending upon the appeal decision.

(5) Eligibility pending appeal shall not be applicable to an appellant appealing an initial denial of eligibility for APTCs.

Section 9. Dismissal of an Appeal. (1) An appeal shall be administratively dismissed by DAH without the need for a final order if the appellant:

- (a) Withdraws the appeal request in accordance with Section 12 of this administrative regulation;
- (b) Fails to appear at a scheduled hearing without good cause;
- (c) Fails to submit a valid appeal request as specified in Section 5 of this administrative regulation; or
- (d) Dies while the appeal is pending.

(2) If an appeal is administratively dismissed in accordance with subsection (1) of this section, DAH shall provide timely written notice:

- (a) To the appellant that includes:
 - 1. The reason for the administrative dismissal;
 - 2. An explanation of the effect of the administrative dismissal on the appellant's eligibility; and
 - 3. An explanation of how the appellant may show good cause why the administrative dismissal should be administratively vacated in accordance with subsection (3)(a) of this section; and
- (b) To the KHBE agency that includes:
 - 1. The eligibility determination to implement; and
 - 2. Discontinuing eligibility provided under Section 8 of this administrative regulation, if applicable.

(3) DAH shall:

(a) Vacate an administrative dismissal under this section and proceed with the appeal if the appellant makes a written request within thirty (30) days of the date of the notice of administrative dismissal showing good cause why the administrative dismissal should be vacated; and

(b) Provide timely written notice of the recommendation to the secretary of the Cabinet for Health and Family Services to deny the request to vacate an administrative dismissal to the appellant, if the request is denied.

Section 10. Hearing Requirements. (1) DAH shall provide written notice to an appellant prior to a hearing with the acknowledgement of appeal request to include:

- (a) Date;
- (b) Time;
- (c) Location;
- (d) Format of the hearing; and
- (e) The requirements in KRS 13B.050.

(2) An appellant shall have the opportunity to:

- (a) Review the appeal record, including all documents and records to be used at the hearing prior to the date of the hearing and during the hearing;
- (b) Bring witnesses to testify;
- (c) Establish all relevant facts and circumstances;
- (d) Present an argument without undue interference; and
- (e) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine an adverse witness.

(3) The DAH shall:

- (a) Consider the information used to determine an appellant's eligibility;
- (b) Consider additional relevant evidence presented during the course of the appeal, including at the hearing; and
- (c) Review the appeal without deference to a prior decision in the appeal case.

(4) A hearing shall be conducted:

- (a) In accordance with the requirements of KRS 13B.080 and KRS 13B.090;
- (b) At a reasonable date, time, and location or format;
- (c) After notice of the hearing provided pursuant to subsection (1) of this section;
- (d) Consistent with subsection (3) of this section; and

(e) By one (1) or more impartial officials who have not been directly involved in the eligibility determination or any prior appeal decision in the same matter.

(5) Unless a request is made by an appellant for an in person hearing, the hearing shall be conducted via telephone.

Section 11. Expedited Appeals. (1) An appellant shall have the right to an expedited appeal if:

- (a) There is an immediate need for a health service; and
- (b) The standard appeal process described in Section 10 of this administrative regulation could seriously endanger the appellant's life, health, or ability to attain, maintain, or regain maximum function.

(2) An expedited appeal shall be requested in the same manner as a standard appeal as set forth in Section 5 of this administrative regulation.

(3) If an expedited appeal is requested, an appellant shall submit evidence of the reason for the expedited appeal.

(4) If an appeal request under this section is denied by the DAH, the DAH shall:

- (a) Conduct the appeal under the standard appeal process as set forth in Section 10 of this administrative regulation;
- (b) Inform the appellant through electronic or oral notification, if possible, of the denial within the timeframes established by the secretary of HHS; and
- (c) If notification is oral, follow up with the appellant by written notice.

(5) A written notice pursuant to subsection (4)(c) of this section shall include:

- (a) The reason for the denial;
- (b) An explanation that the appeal request will be transferred to the standard process described in Section 10 of this administrative regulation; and
- (c) An explanation of the appellant's rights under the standard process in Section 10 of this administrative regulation.

Section 12. Withdrawal of an Appeal. An appellant shall withdraw a request for an appeal:

- (1) In writing;
- (2) By phone by contacting the kynector contact center; or
- (3) Orally to the hearing officer during an appeal proceeding.

Section 13. Hearing Decision. (1) After the hearing is concluded or a decision is made not to reverse an administrative dismissal of an appeal, the hearing officer shall issue a recommended order in accordance with the requirements of KRS 13B.110.

(2) A recommended order rendered by the DAH shall be based only on the:

- (a) Information and evidence specified in 45 C.F.R. 155.535(e);
- (b) Eligibility requirements in 900 KAR 10:030; and
- (c) Eligibility requirements under 45 C.F.R. subpart D.

(3) A recommended order shall:

- (a) Be sent to the appellant and the appellant's authorized representative, if applicable, and KBHE;
- (b) State the decision;
- (c) Include a plain language description of the effect of the decision on an appellant's eligibility;
- (d) Summarize the facts relevant to the appeal;
- (e) Identify the legal basis, including an administrative regulation that supports the decision; and
- (f) State the effective date of the decision.

(4) If either the appellant or KHBE is dissatisfied with the recommended order, either party shall have fifteen (15) days from the date the recommended order is mailed to file exceptions to the recommendations with the secretary of the Cabinet for Health and Family Services.

(5) The secretary of the Cabinet for Health and Family Services shall consider the appeal record, including the recommended order and any exceptions filed to a recommended order in accordance with KRS 13B.120.

(6) The secretary of the Cabinet for Health and Family Services may:

(a) Accept the recommended order of the hearing officer and adopt it as the agency's final order;

(b) Reject or modify, in whole or in part, the recommended order; or

(c) Remand the matter, in whole or in part, to the hearing officer for further proceedings as appropriate.

(7) The secretary of the Cabinet for Health and Family Services shall:

(a) Issue written notice of the final order to the appellant within ninety (90) days of the date an appeal request under Section 5 of this administrative regulation is received;

(b) In the case of an appeal request submitted under Section 11 of this administrative regulation that is determined to meet the criteria for an expedited appeal, issue the final order as expeditiously as:

1. The appellant's health condition requires; and

2. Reasonably possible, consistent with the timeframe established by the secretary of HHS; and

(c) Provide notice of the appeal decision and instructions to cease pended eligibility to:

1. The appellant, if applicable; and

2. KHBE.

(8) Upon receipt of a notice described in subsection (7) of this section, the KHBE shall:

(a) Implement the appeal decision:

1. Retroactive to the date the incorrect eligibility determination was made; or

2. At a time determined under 45 C.F.R. 155.330(f); and

(b) Redetermine the eligibility of a household member who has not appealed an eligibility determination but whose eligibility may be affected by the appeal decision, in accordance with the standards described in:

1. 900 KAR 10:030; and

2. 45 C.F.R. 155.305.

Section 14. Right to Appeal to HHS. (1) If an appellant disagrees with an appeal decision made in accordance with Section 13 of this administrative regulation or notice of denial of a request to vacate a dismissal under Section 9(3)(b) of this administrative regulation, the appellant may request an appeal from HHS within thirty (30) days of the date of the appeal notice.

(2) Upon receipt of a notice of an appeal under subsection (1) of this section, DAH shall transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record received from KHBE, to HHS.

(3) An applicant or an enrollee denied a request for an exemption by HHS under 45 C.F.R. 155.625(b) may appeal the decision to HHS.

Section 15. Release of Records. (1) An appellant shall have access to the information used by the KHBE to determine his or her eligibility.

(2) An appellant shall have access to his or her appeal record:

(a) Upon written request;

(b) At a place and time convenient to the appellant; and

(c) Subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

(3) The public shall have access to an appeal decision, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

CARRIE BANAHAN, Executive Director

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 4, 2013

FILED WITH LRC: December 17, 2013 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014, at 9:00 a.m. in the Public Health Auditorium located on the First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, 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 policies and procedures relating to appeals of eligibility determinations for KHBE participation and insurance affordability programs in accordance with 42 U.S.C. 18031 and 45 C.F.R. parts 155 and 156..

(b) The necessity of this administrative regulation: This administrative regulation is necessary to develop the policies and procedures that will be used for an individual seeking to appeal a decision of the Kentucky Health Benefit Exchange regarding eligibility.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary so that individuals seeking to file an appeal of an eligibility determination issued by the Kentucky Health Benefit Exchange are informed of the steps necessary to file an appeal and the subsequent actions of the Cabinet related to the appeal.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed information to individuals seeking to file an appeal of an eligibility determination issued by the Kentucky Health Benefit Exchange so that they may avail themselves of their rights to an appeal.

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 500 individuals who may make an appeal of their determination of edibility issued by 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 individual seeking to file an appeal of a determination of eligibility issued by the Kentucky Health Benefit Exchange must file a request for an appeal pursuant to 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): There will be no cost to entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This administrative regulation will

benefit each individual that may request an appeal of an eligibility determination issued by the Kentucky Health Benefit Exchange by providing detailed instructions regarding the appeals process.

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. Part 155.

(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 an appeal of a determination of eligibility issued by 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 develop policies and procedures related to individual appeals of eligibility determinations issued by KHBE.

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

Division of Policy and Operations

(New Administrative Regulation)

907 KAR 1:632. Vision Program coverage provisions and requirements.

RELATES TO: KRS 205.520, 42 C.F.R. 440.40, 440.60, 447 Subpart B, 42 U.S.C. 1396a-d, 45 C.F.R. 147.126

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1)

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 Kentucky Medicaid Program provisions and requirements regarding the coverage of vision services.

Section 1. Definitions. (1) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

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

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Healthcare common procedure coding system" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services that represent procedures or items.

(6) "Managed care organization" 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.

(7) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(8) "Ophthalmic dispenser" means an individual who is qualified to engage in the practice of ophthalmic dispensing in accordance with KRS 326.030 or 326.040.

(9) "Optometrist" is defined by KRS 311.271.

- (10) "Provider" is defined by KRS 205.8451(7).
(11) "Recipient" is defined by KRS 205.8451(9).

Section 2. General Requirements. (1)(a) For the department to reimburse for a vision service or item the service or item shall be:

1. Provided:
 - a. To a recipient; and
 - b. By a provider who is:
 - (i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;
 - (ii) Currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and
 - (iii) Authorized by this administrative regulation to provide the given service or item;
2. Covered in according with this administrative regulation;
3. Medically necessary;
4. A service or item authorized within the scope of the provider's licensure; and
5. A service or item listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) In accordance with Section 3(3) of 907 KAR 17:010, a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2)(a) To be recognized as an authorized provider of visions services, an optometrist shall:

1. Be certified by the:
 - a. Kentucky Board of Optometric Examiners; or
 - b. Optometric examiner board in which the optometrist practices if the optometrist practices in a state other than Kentucky;
2. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and
3. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(b)1. To be recognized as an authorized provider of visions services, an in-state optician shall:

- a. Hold a current license in Kentucky as an ophthalmic dispenser;
- b. Comply with the requirements established in KRS Chapter 326;
- c. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and
- d. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

2. To be recognized as an authorized provider of visions services, an out-of-state optician shall:

- a. Hold a current license in the state in which the optician practices as an ophthalmic dispenser;
- b. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and
- c. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(3)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and
2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department for multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(4) A provider shall comply with:

- (a) 907 KAR 1:671;
- (b) 907 KAR 1:672; and
- (c) All applicable state and federal laws.

(5)(a) If a provider receives any duplicate or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in

accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(6) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 3. Vision Service Coverage. (1) Vision service coverage shall be limited to a service listed with a CPT code on the Department for Medicaid Services Vision Program Fee Schedule.

(2) Vision service limits shall be as established on the Department for Medicaid Services Vision Program Fee Schedule.

Section 4. Coverage of Eyeglasses and Frames. (1) To be eligible for eyeglasses covered by the department, a recipient shall:

(a) Be under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21) years of age; and

(b) Have a diagnosed visual condition that:

1. Requires the use of eyeglasses;
2. Is within one (1) of the following categories:
 - a. Amblyopia;
 - b. Post surgical eye condition;
 - c. Diminished or subnormal vision; or
 - d. Other diagnosis which indicates the need for eyeglasses;

and

3. Requires a prescription correction in the stronger lens no weaker than:

- a. +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
- b. 0.50 diopter of vertical prism; or
- c. A total of (two) 2 diopter of lateral prism.

(2)(a) The department shall reimburse for no more than one (1) pair of eyeglasses per recipient per twelve (12) consecutive month period unless:

1. The recipient's eyeglasses are broken or lost during the twelve (12) consecutive month period; or
2. The eyeglass prescription for the recipient is changed during the twelve (12) consecutive month period.

(b) If an event referenced in paragraph (a)1 or 2 occurs within the twelve (12) consecutive month period, the department shall reimburse for one (1) additional pair of eyeglasses for the recipient during the twelve (12) consecutive month period.

(3) For the department to cover:

(a) A frame, the frame shall be:

1. First quality;
2. Free of defects; and
3. Have a warranty of at least one (1) year; or

(b) A lens, the lens shall be:

1. First quality;
2. Free of defects;
3. Meet the United States Food and Drug Administration's impact resistance standards; and
4. Polycarbonate and scratch coated.

(4) The dispensing of eyeglasses shall include:

- (a) Single vision prescriptions;
- (b) Bi-focal vision prescriptions;
- (c) Multi-focal vision prescriptions;
- (d) Services to frames; or
- (e) Delivery of the completed eyeglasses which shall include:
 1. Instructions in the use and care of the eyeglasses; and
 2. Any adjustment, minor or otherwise, for a period of one (1) year.

(5) A provider shall be responsible, at no additional cost to the department or the recipient, for:

- (a) An inaccurately filled prescription;

- (b) Defective material; or
- (c) An improperly fitted frame.

Section 5. Contact Lenses, Tint, and Plano Safety Glasses. (1) The department shall not reimburse for contact lenses substituted for eyeglasses unless:

- (a) The corrected acuity in a recipient's stronger eye is twenty (20)/fifty (50) and shall be improved with the use of contact lenses;
 - (b) The visual prescription is of ± 8.00 diopter or greater; or
 - (c) The recipient's diagnosis is 4.00 diopter anisometropia.
- (2) The department shall not reimburse for tint unless the prescription specifically indicates a diagnosis of photophobia.
- (3) The department shall not reimburse for plano safety glasses unless the glasses are medically indicated for the recipient.

Section 6. Noncovered Services or Items. The department shall not reimburse for:

- (1) Tinting if not medically necessary;
- (2) Photochromics if not medically necessary;
- (3) Anti-reflective coatings if not medically necessary;
- (4) Other lens options which are not medically necessary;
- (5) Low vision services;
- (6) A press-on prism; or
- (7) A service with a CPT code or item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 7. Required Provider Documentation. (1)(a) In accordance with 42 C.F.R. 431.17, a provider shall maintain medical records of a service provided to a recipient for the period of time currently required by the United States Health and Human Services Secretary unless the department requires a retention period, pursuant to 907 KAR 1:671, longer than the period required by the United States Health and Human Services Secretary.

(b) If, pursuant to 907 KAR 1:671, the department requires a medical record retention period longer than the period required by the United States Health and Human Services Secretary, the medical record retention period established in 907 KAR 1:671 shall be the minimum record retention period.

(c) A provider shall maintain medical records of a service provided to a recipient in accordance with:

- 1. 45 C.F.R. 164.316; and
- 2. 45 C.F.R. 164.306.

(2) A provider shall maintain the following documentation in a recipient's medical record:

- (a) Any covered service or covered item provided to the recipient;
- (b) For each covered service or covered item provided to the recipient:
 - 1. A signature by the individual who provided the service or item signed on the date the service or item was provided;
 - 2. The date that the service or item was provided; and
 - 3. Demonstration that the covered service or covered item was provided to the recipient;
- (c) The diagnostic condition necessitating the service or item; and
- (d) The medical necessity as substantiated by an appropriate medical order.

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 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, or 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 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 upon request.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeal Rights. An appeal of a department decision regarding a Medicaid recipient who is:

- (1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or
- (2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

Section 11. Incorporation by Reference. (1) "Department for Medicaid Services Vision Program Fee Schedule", December 2013, 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, Monday through Friday, 8 a.m. to 4:30 p.m. or 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 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes Medicaid Program coverage policies and requirements regarding vision services. Previously, vision coverage provisions were addressed in 907 KAR 1:038, Hearing Program coverage provisions and requirements, which also established hearing coverage provisions. The Department for Medicaid Services (DMS) is creating this administrative regulation to separate vision coverage provisions from hearing coverage

provisions which will remain in 907 KAR 1:038; thus, this administrative regulation is being promulgated in conjunction with 907 KAR 1:038E. Additionally, DMS is promulgating 907 KAR 1:039E, Hearing Program reimbursement provisions and requirements as well as 907 KAR 1:631E, Vision Program reimbursement provisions and requirements in conjunction with this administrative regulation. Though this is a new administrative regulation it does contain amended provisions. The primary amendment is eliminating, from the Vision Program, an annual dollar limit on eyeglasses. Currently, DMS has an annual eyeglass dollar limit of \$200 per year or \$400 per year depending on the recipient's benefit plan; however, DMS is eliminating the dollar limit and establishing that DMS will reimburse for up to two (2) pairs of eyeglasses per twelve (12) consecutive month period [one (1) pair is covered with an additional pair allowed if the individual's glasses are broken or lost or the prescription changes]. Another critical amendment is establishing that DMS's coverage of Vision Program services is contingent upon receipt of federal approval and federal funding. Additional amendments include the elimination of a manual - Vision Program Manual – that DMS incorporated by reference 907 KAR 1:038 and inserting electronic signature requirements to enable providers to sign via electronic signatures. DMS is no longer incorporating the manual by reference into regulation but is incorporating the Department for Medicaid Services Vision Program Fee Schedule by reference into this administrative regulation. The fee schedule limits eye examinations to one (1) per recipient per year in contrast to the current limit of one (1) per recipient per provider per year. The administrative regulation also contains program integrity requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid Program coverage provisions and requirements regarding vision services. Eliminating, from the Vision Program, the \$200 and \$400 annual limits on eye glasses is necessary to comply with a federal mandate. The Affordable Care Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as "essential health benefits." Medicaid benefits are within the scope of essential health benefits. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided. Program integrity provisions are necessary to enhance the integrity of the program and adopting the Vision Program Fee Schedule is necessary to give providers a user friendly document regarding covered 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 Medicaid Program coverage provisions and requirements regarding vision services; by complying with a federal mandate; and by protecting Kentucky taxpayer monies from being spent if federal matching funds are not provided.

(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 coverage provisions and requirements regarding vision services; by complying with a federal mandate; and by protecting Kentucky taxpayer monies from being spent if federal matching funds are not provided.

(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 but it establishes Medicaid Program coverage provisions and requirements regarding vision services that were previously established in another administrative regulation. Please see the response to question (1)(a) for more information..)

(b) The necessity of the amendment to this administrative regulation: Please see the response to question (1)(b).

(c) How the amendment conforms to the content of the authorizing statutes: Please see the response to question (1)(c).

(d) How the amendment will assist in the effective administration of the statutes: Please see the response to question (1)(d).

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect vision service providers participating in the Kentucky Medicaid program. For calendar year 2012, twenty-two (22) opticians billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and 614 optometrists billed claims to the Medicaid program. 7,298 individuals (managed care and fee-for-service combined) received services from opticians in calendar year 2012 and 187,896 individuals received services from optometrists (managed care and fee-for-service combined) during the same period.

(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 the regulated entities other than to properly bill for services and adhere to program integrity requirements.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients who need eyeglasses may benefit from altering the annual cap of \$200 or \$400 to up to two (2) pair of eyeglasses per year (if they meet the qualifying circumstances – the first pair of eyeglasses is lost or broken or the prescription changes.)

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

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(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, state matching funds, 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: No increase in funding will be necessary to implement this administrative regulation.

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

(9) Tiering: Is tiering applied? Tiering is applied as eyeglass coverage is only available to those under twenty-one (21). 42 C.F.R. 441.56(c)(1) – which addresses early and periodic screening, diagnosis and treatment (EPSDT) services coverage – mandates coverage for individuals under twenty-one (21).

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30)(A), 42 U.S.C. 1396a(a)(33), 42 C.F.R. 441.56(c)(1), 42 C.F.R. 441.30, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. Vision services for Medicaid recipients are not mandated by Kentucky law; however, the

Department for Medicaid Services is required by KRS 205.8453 to "institute other measures necessary or useful in controlling fraud and abuse." KRS 205.520(3) states: "...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. Vision services are not federally mandated except for those under age twenty-one (21) via the early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age twenty-one (21) program pursuant to 42 C.F.R. 441.56(c)(1). 42 C.F.R. 441.30 states, "The plan must provide for payment of optometric services as physician services, whether furnished by an optometrist or a physician, if:

(a) The plan does not provide for payment for services provided by an optometrist, except for eligibility determinations under §§435.531 and 436.531 of this subchapter, but did provide for those services at an earlier period; and

(b) The plan specifically provides that physicians' services include services an optometrist is legally authorized to perform." Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care.

42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services..."

45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1), and 45 C.F.R. 147.126.

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 expects that the amendment will not generate revenue.

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

(c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services

(DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

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 Policy and Operations

(New Administrative Regulation)

907 KAR 8:005. Definitions for 907 KAR Chapter 8.

RELATES TO: 194A.025(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

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. This administrative regulation establishes the definitions for administrative regulations in 907 KAR Chapter 8.

Section 1. Definitions. (1) "Adult" means an individual who is at least twenty-one (21) years of age.

(2) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(3) "Child" means an individual who is under twenty-one (21) years of age.

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

(5) "Electronic signature" is defined by KRS 369.102(8).

(6) "Enrollee" means a recipient who is enrolled with a managed care organization.

(7) "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.

(8) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

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

(10) "Occupational therapy assistant" is defined by KRS 319A.010(4).

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

(12) "Physician assistant" is defined by KRS 311.840(3).

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

(14) "Physical therapy 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.

(15) "Prior authorized" means authorized by:

(a) The department if the service is for a recipient who is not an enrollee; or

(b) A managed care organization if the service is for an enrollee.

(16) "Provider" is defined by KRS 205.8451(7).

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

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

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy. The Department for Medicaid Services currently covers these therapies in various settings (for example, home health agencies, physician's offices, outpatient hospitals, nursing facilities) but does not allow these practitioners to enroll as independent providers in the Medicaid Program. Instead, the practitioners have to work for or under contract with a provider type (such as the aforementioned) that is authorized to provide therapy. DMS is promulgating, in conjunction with this administrative regulation, six (6) other administrative regulations which will authorize occupational therapists, physical therapists, and speech language pathologists to enroll in the Medicaid Program, provide services to Medicaid recipients, and be reimbursed directly by the Medicaid Program for the services. The six (6) other administrative regulations are 907 KAR 8:010, Occupational therapy coverage provisions and requirements; 907 KAR 8:015, Reimbursement for occupational therapy; 907 KAR 8:020, Physical therapy coverage provisions and requirements; 907 KAR 8:025, Reimbursement for physical therapy; 907 KAR 8:030, Speech therapy coverage provisions and requirements; and 907 KAR 8:035, Reimbursement for speech therapy.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the

definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 8. Chapter 8 contains Medicaid administrative regulations regarding independent occupational therapy, independent physical therapy, and independent speech therapy.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any occupational therapist, physical therapist, or speech-language pathologist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for services provided to Medicaid recipients. The Department for Medicaid Services (DMS) is unable to predict how many such individuals will choose to enroll in the Medicaid Program.

(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. An occupational therapist, a physical therapist, or a speech-language pathologist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). An occupational therapist, a physical therapist, or a speech-language pathologist therapist who wishes to provide services to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An occupational therapist, a physical therapist, or a speech-language pathologist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients.

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

(a) Initially: No cost is necessary to initially implement this administrative regulation as it is simply a definitions administrative regulation.

(b) On a continuing basis: No continuing cost is necessary to implement this administrative regulation as it is simply a definitions administrative regulation.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds

authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

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

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions for 907 KAR Chapter 8.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation.

2. State compliance standards. KRS 194A.030(2) states, "The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act."

3. Minimum or uniform standards contained in the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation. There is; however, a mandate to ensure recipient access to services covered by the state's Medicaid program. As the Department for Medicaid Services (DMS) covers occupational therapy services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

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? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this administrative regulation in the first year.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary in subsequent years to implement this administrative regulation.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Administrative Regulation)

907 KAR 8:010. Independent occupational therapy service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding occupational therapy services provided by an independent occupational therapist or occupational therapy assistant working under the direct supervision of an independent occupational therapist.

Section 1. Provider Participation. (1)(a) To be eligible to provide and be reimbursed for an occupational therapy service as an independent provider, a provider shall be:

1. Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

2. Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

3. An occupational therapist.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2) Occupational therapy services provided in accordance with Section 2 of this administrative regulation by an occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in subsection (1) of this section shall be reimbursable if the occupational therapist is the biller for the services.

Section 2. Coverage and Limit. (1) The department shall reimburse for an occupational therapy service if:

(a) The service:

1. Is provided:

a. By an:

(i) Occupational therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible

functioning level;

3. Is prior authorized; and

4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by an occupational therapist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each service visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 3. No Duplication of Service. (1) The department shall not reimburse for an occupational therapy service provided to a recipient by more than one (1) provider of any program in which occupational therapy services are covered during the same time period.

(2) For example, if a recipient is receiving an occupational therapy service from an occupational therapist enrolled with the Medicaid Program, the department shall not reimburse for the same occupational therapy service provided to the same recipient during the same time period via the home health program.

Section 4. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2) A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(3) The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(4)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(5) A provider shall comply with 45 C.F.R. Part 164.

Section 5. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 8. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program coverage of occupational therapy services provided by an independently

enrolled occupational therapist or occupational therapy assistant working under the direct supervision of an independently enrolled occupational therapist. Currently, the Department for Medicaid Services (DMS) covers occupational therapy services when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This authorizes occupational therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for occupational therapy services provided to Medicaid recipients. DMS is expanding the occupational therapy service provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. Additionally, DMS anticipates many individuals who previously qualified for Medicaid benefits, but did not apply for benefits will seek benefits as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:015, Independent occupational therapy service reimbursement provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of occupational therapy service providers in order to meet the demand for care (thus, to ensure recipient access to care.) The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133% of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Additionally, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an

amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any occupational therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for occupational therapy services provided to Medicaid recipients. Similarly, occupational therapy assistants who wish to work for/under the supervision of an independently enrolled occupational therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of occupational therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many occupational therapists will choose to enroll in the Medicaid Program, nor how many occupational therapy assistants will elect to work for/under the supervision of an independently enrolled occupational therapists, nor how many Medicaid recipients will receive services from independently enrolled occupational therapists.

(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. An occupational therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). An occupational therapist who wishes to provide occupational therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An occupational therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Occupational therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of occupational therapy services will benefit from an expanded base of providers from which to receive occupational therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this

administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover occupational therapy services; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers occupational therapy services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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 Policy and Operations

(New Administrative Regulation)

907 KAR 8:015. Independent occupational therapy service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding occupational therapy services provided by an independent occupational therapist, or an occupational therapy assistant working under the direct supervision of an independent occupational therapist, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. (1) For the department to reimburse for an occupational therapy service under this administrative regulation, the:

(a) Occupational therapist shall meet the provider requirements established in 907 KAR 8:010; and

(b) Service shall meet the coverage and related requirements established in 907 KAR 8:010.

(2) Occupational therapy services provided in accordance with 907 KAR 8:010 and by an occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in 907 KAR 8:010 shall be reimbursable if the occupational therapist is the biller for the therapy.

Section 2. Reimbursement. The department shall reimburse for an occupational therapy service provided by an:

(1) Occupational therapist, in accordance with 907 KAR 8:010 and Section 2 of this administrative regulation, at 63.75 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule; or

(2) Occupational therapy assistant working for an occupational therapist, in accordance with 907 KAR 8:010 and Section 2 of this administrative regulation, at 37.5 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 8:010; and

(2) This administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding occupational therapy services provided by an independently enrolled occupational therapists, or occupational therapy assistant working under the direct supervision of an independently enrolled occupational therapist, to Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for occupational therapy services pursuant to this administrative regulation. Currently, the Department for Medicaid Services (DMS) covers occupational therapy services when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This administrative regulation authorizes occupational therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for occupational therapy services provided to Medicaid recipients. DMS is expanding the occupational therapy service provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group

known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. DMS must expand its provider base to meet the demand of the additional Medicaid recipients DMS anticipates beginning January 1, 2014 (in order to ensure recipient access to care.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:010, Independent occupational therapy service coverage provisions and requirements and 907 KAR 8:005, Definitions for KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of occupational therapy service providers in order to meet the demand for care (thus, to ensure recipient access to care.)

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any occupational therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for occupational therapy services provided to Medicaid recipients. Similarly, occupational therapy assistants who wish to work for/under the supervision of an independently enrolled occupational therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of occupational therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many occupational therapists will choose to enroll in the Medicaid Program, nor how many occupational therapy assistants will elect to work for/under the supervision of an independently enrolled occupational therapists, nor how many Medicaid recipients will receive services from independently enrolled occupational therapists.

(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. An occupational therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or

amendment, how much will it cost each of the entities identified in question (3). An occupational therapist who wishes to provide occupational therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An occupational therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Occupational therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of occupational therapy services will benefit from an expanded base of providers from which to receive occupational therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover occupational therapy services; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers occupational therapy services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the

intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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 Policy and Operations
(New Administrative Regulation)

907 KAR 8:020. Independent physical therapy service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding physical therapy services provided by an independent physical therapist or physical therapy assistant working under the direct supervision of an

independent physical therapist.

Section 1. Provider Participation. (1)(a) To be eligible to provide and be reimbursed for physical therapy as an independent provider, a provider shall be:

1. Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

2. Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

3. A physical therapist.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2) Physical therapy provided in accordance with Section 2 of this administrative regulation by a physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in subsection (1) of this section may be reimbursable if the physical therapist is the biller for the therapy.

Section 2. Coverage and Limit. (1) The department shall reimburse for physical therapy if:

(a) The therapy:

1. Is provided:

a. By a:

(i) Physical therapist who meets the requirements in Section 1(1) of this administrative regulation; or

(ii) Physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in Section 1(1) of this administrative regulation; and

b. To a recipient;

2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:

a. Maximum reduction of a physical or intellectual disability; or

b. Restoration of a recipient to the recipient's best possible functioning level;

3. Is prior authorized; and

4. Is medically necessary; and

(b) A specific amount of visits is requested for the recipient by a physical therapist, physician, physician assistant, or an advanced practice registered nurse.

(2)(a) There shall be an annual limit of twenty (20) physical therapy visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each therapy visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 3. No Duplication of Service. (1) The department shall not reimburse for physical therapy provided to a recipient by more than one (1) provider of any program in which physical therapy is covered during the same time period.

(2) For example, if a recipient is receiving physical therapy from a physical therapist enrolled with the Medicaid Program, the department shall not reimburse for physical therapy provided to the same recipient during the same time period via the home health program.

Section 4. Records Maintenance, Protection, and Security.

(1)(a) A provider shall maintain a current health record for each recipient;

(b) 1. A health record shall document each service provided to the recipient including the date of the service and the signature of

the individual who provided the service; and

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years; and

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Part 164.

Section 5. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 8. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program coverage of physical therapy provided by an independently enrolled physical therapist or physical therapy assistant working under the direct supervision of an independently enrolled physical therapist. Currently, the Department for Medicaid Services (DMS) covers physical therapy when provided in a physician's office (and the physician is the billing entity), when provided in an outpatient hospital (when the outpatient hospital is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This authorizes physical therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for physical therapy provided to Medicaid recipients. DMS is expanding the physical therapy provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. Additionally, DMS anticipates many individuals who previously qualified for Medicaid benefits, but did not apply for benefits will seek benefits as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:025, Independent physical therapy service reimbursement provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of physical therapy providers in order to meet the demand for care (thus, to ensure recipient access to care.) The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133% of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Additionally, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any physical therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for physical therapy services provided to Medicaid recipients. Similarly, physical therapy assistants who wish to work for/under the supervision of an independently enrolled physical therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of physical therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many physical therapists will choose to enroll in the Medicaid Program, nor how many physical therapy assistants will elect to work for/under the supervision of an independently enrolled physical therapists, nor how many Medicaid recipients will receive services from independently enrolled physical therapists.

(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 physical therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the

individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A physical therapist who wishes to provide physical therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A physical therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Physical therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of physical therapy services will benefit from an expanded base of providers from which to receive physical therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover physical therapy; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers physical therapy, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in

the geographic area. "Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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 Policy and Operations

(New Administrative Regulation)

907 KAR 8:025. Physical therapy service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding physical therapy services provided by an independent physical

therapist, or physical therapy assistant working under the direct supervision of an independent physical therapist, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. (1) For the department to reimburse for physical therapy under this administrative regulation, the:

(a) Physical therapist shall meet the provider requirements established in 907 KAR 8:020; and

(b) Physical therapy shall meet the coverage and related requirements established in 907 KAR 8:020.

(2) Physical therapy provided in accordance with 907 KAR 8:020 and by a physical therapy assistant who works under the direct supervision of a physical therapist who meets the requirements in 907 KAR 8:020 shall be reimbursable if the physical therapist is the biller for the therapy.

Section 2. Reimbursement. The department shall reimburse for a physical therapy service provided by a:

(1) Physical therapist, in accordance with 907 KAR 8:020 and Section 2 of this administrative regulation, at 63.75 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule; or

(2) Physical therapy assistant working for a physical therapist, in accordance with 907 KAR 8:020 and Section 2 of this administrative regulation, at 37.5 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 8:020; and

(2) This administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding physical therapy services provided by an independently enrolled physical therapist, or physical therapy assistant working under the direct supervision of an independently enrolled physical therapist, to Medicaid recipients who are not enrolled with a managed care organization.. Managed care organizations are not required to reimburse for physical therapy services pursuant to this administrative regulation. Currently, the Department for Medicaid Services (DMS) covers physical therapy when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in an outpatient hospital (billed by the outpatient hospital), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This administrative regulation authorizes physical therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for physical therapy provided to Medicaid recipients. DMS is expanding the physical therapy provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. DMS must expand its provider base to meet the demand of the additional Medicaid recipients DMS anticipates beginning January 1, 2014 (in order to ensure recipient access to care.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:020, Independent physical therapy service coverage provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of physical therapy providers in order to meet the demand for care (thus, to ensure recipient access to care.)

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective

administration of the statutes: This is a new administrative regulation rather than 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: Any physical therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for physical therapy services provided to Medicaid recipients. Similarly, physical therapy assistants who wish to work for/under the supervision of an independently enrolled physical therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of physical therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many physical therapists will choose to enroll in the Medicaid Program, nor how many physical therapy assistants will elect to work for/under the supervision of independently enrolled physical therapists, nor how many Medicaid recipients will receive services from independently enrolled physical therapists.

(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 physical therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A physical therapist who wishes to provide physical therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A physical therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Physical therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of physical therapy services will benefit from an expanded base of providers from which to receive physical therapy services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover physical therapy; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers physical therapy, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually,

beginning with state fiscal year 2015.

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 Policy and Operations
(New Administrative Regulation)

907 KAR 8:030. Independent speech pathology service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding speech pathology services provided by an independent speech-language pathologist.

Section 1. Provider Participation. (1) To be eligible to provide and be reimbursed for speech pathology services as an independent provider a provider shall be:

- (a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;
- (b) Except as established in paragraph (b) of this subsection, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and
- (c) A speech-language pathologist.

(2) In accordance with 907 KAR 17:010, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 2. Coverage and Limit. (1) The department shall reimburse for a speech pathology service if:

- (a) The service:
 1. Is provided:
 - a. By a speech-language pathologist who meets the requirements in Section 1(1) of this administrative regulation; and
 - b. To a recipient;
 2. Is ordered for the recipient by a physician, physician assistant, or advanced practice registered nurse for:
 - a. Maximum reduction of a physical or intellectual disability; or
 - b. Restoration of a recipient to the recipient's best possible functioning level;
 3. Is prior authorized; and
 4. Is medically necessary; and
- (b) A specific amount of visits is requested for the recipient by a speech-language pathologist, physician, physician assistant, or an advanced practice registered nurse.
 - (2)(a) There shall be an annual limit of twenty (20) speech pathology service visits per recipient per calendar year except as established in paragraph (b) of this subsection.
 - (b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:
 1. Department if the recipient is not enrolled with a managed care organization; or
 2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.
 - (c) Prior authorization by the department shall be required for

each speech pathology service that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 3. No Duplication of Service. (1) The department shall not reimburse for a speech pathology service provided to a recipient by more than one (1) provider of any program in which speech pathology service is covered during the same time period.

(2) For example, if a recipient is receiving a speech pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the speech pathology service provided to the same recipient during the same time period via the home health program.

Section 4. Records Maintenance, Protection, and Security. (1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Chapter 164.

Section 5. Medicaid Program Participation Compliance. (1) A provider shall comply with:

- (a) 907 KAR 1:671;
- (b) 907 KAR 1:672; and
- (c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and
2. Prosecuted in accordance with applicable federal or state law.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. 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 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, or 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 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 8. Auditing Authority. The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program coverage of speech pathology services provided by an independently enrolled speech-language pathologist. Currently, the Department for Medicaid Services (DMS) covers speech pathology services when provided in a physician's office (and the physician is the billing entity), when provided in an outpatient hospital (when the outpatient hospital is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This authorizes speech-language pathologists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for speech pathology services provided to Medicaid recipients. DMS is expanding the speech pathology services provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act

created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. Additionally, DMS anticipates many individuals who previously qualified for Medicaid benefits, but did not apply for benefits will seek benefits as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:035, Independent speech-pathology service reimbursement provisions and requirements and 907 KAR 8:005, Definitions for 907 KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of speech pathology service providers in order to meet the demand for care (thus, to ensure recipient access to care.) The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Additionally, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any speech-language pathologist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for speech pathology services provided to Medicaid recipients. Additionally,

Medicaid recipients in need of speech pathology services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many speech-language pathologists will choose to enroll in the Medicaid Program nor how many Medicaid recipients will receive services from independently enrolled speech-language pathologists.

(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 speech-language pathologist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the provider wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A speech-language pathologist who wishes to provide speech pathology services to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A speech-language pathologist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Medicaid recipients in need of speech pathology services will benefit from an expanded base of providers from which to receive speech pathology services.

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover speech pathology services; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers speech pathology services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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 Policy and Operations
(New Administrative Regulation)**

907 KAR 8:035. Speech language pathology service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding speech language pathology services provided by an independent speech-language pathologist to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. For the department to reimburse for a speech language pathology service under this administrative regulation, the:

(1) Speech-language pathologist shall meet the provider requirements established in 907 KAR 8:030; and

(2) Speech language pathology service shall meet the coverage and related requirements established in 907 KAR 8:030.

Section 2. Reimbursement. The department shall reimburse for a speech language pathology service provided by a speech-language pathologist, in accordance with 907 KAR 8:030 and Section 2 of this administrative regulation, at 63.75 percent of the rate for the service listed on the Kentucky-specific Medicare Physician Fee Schedule.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 8:030; and

(2) This administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding speech pathology services provided by an independently enrolled speech-language pathologist to Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for speech pathology services pursuant to this administrative regulation. Currently, the Department for Medicaid Services (DMS) covers speech pathology services when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in an outpatient hospital (billed by the outpatient hospital), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This administrative regulation authorizes speech-language pathologists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for speech pathology services provided to Medicaid recipients. DMS is expanding the speech pathology service provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. DMS must expand its provider base to meet the demand of the additional Medicaid recipients DMS anticipates beginning January 1, 2014 (in order to ensure recipient access to care.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:030, Independent speech pathology service coverage provisions and requirements and 907 KAR 8:005, Definitions for KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of speech pathology service providers in order to meet the demand for care (thus, to ensure recipient access to care.)

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: Any speech-language pathologist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for speech pathology services provided to Medicaid recipients. Additionally, Medicaid recipients in need of speech pathology services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many speech-language pathologists will choose to enroll in the Medicaid Program nor how many Medicaid recipients will receive services from independently enrolled speech-language pathologists.

(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 physical therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A physical therapist who wishes to provide speech pathology to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A speech-language pathologist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Medicaid recipients in need of speech pathology services will benefit from an expanded base of providers from which to receive speech pathology services

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

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(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 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 to implement this administrative regulation.

(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

policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

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. Medicaid programs are not required to cover speech pathology; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers speech pathology services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

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 the amendment to 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? No revenue is anticipated.

(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 is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by \$1.43 million (\$271,530 state funds/\$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for

subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately \$1.91 million (\$362,000 state funds/\$1.55 million federal funds) annually, beginning with state fiscal year 2015.

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 Policy and Operations
(New Administrative Regulation)

907 KAR 13:005. Definitions for 907 KAR Chapter 13.

RELATES TO: 194A.025(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

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. This administrative regulation establishes the definitions for 907 KAR Chapter 13.

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services or its designee.

(2) "Electronic signature" is defined by KRS 369.102(8).

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Home health agency" or "HHA" means a Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.

(5) "Immediate family member" is defined by KRS 205.8451(3).

(6) "Licensed practical nurse" is defined by KRS 314.011(9).

(7) "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.

(8) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Prior authorized" means authorized by:

(a) The department if the service is for a recipient who is not an enrollee; or

(b) A managed care organization if the service is for an enrollee.

(10) "Private duty nursing agency" means an agency licensed in accordance with 902 KAR 20:370.

(11) "Provider" is defined by KRS 205.8451(7).

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

(13) "Registered nurse" is defined by KRS 314.011(5).

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations located in 907 KAR Chapter 13 of the Kentucky Administrative Regulations. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing services. These are new services being covered by the Department for Medicaid Services (DMS) resulting from DMS's implementation of an alternative benefit plan (based on a "benchmark" or "benchmark equivalent plan") as required by the Affordable Care Act. Any state which expands its Medicaid eligibility groups to include the "expansion group" authorized by the Affordable Care Act is required to establish an alternative benefit plan for the expansion group. The expansion group is comprised primarily of adults under age sixty-five (65) who are not pregnant, who have income below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid benefits. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The benchmark plan or benchmark equivalent plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish a benchmark plan or benchmark equivalent plan for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to use the same "benchmark" or "benchmark equivalent plan" as the health benefit exchange to establish the alternative benefit plan for the Medicaid expansion group. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS's benefit plan will be the same for all Medicaid recipients – existing populations as well as new eligibility groups authorized or mandated by the Affordable Care Act. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010,

private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: There are currently thirteen (13) private duty nursing agencies licensed in Kentucky and 109 home health agencies licensed 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. A private duty nursing agency that wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization. A home health agency that wishes to provide Medicaid-covered private duty nurse services must obtain a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General in accordance with 902 KAR 20:370 and also enroll with the Medicaid Program as mentioned above for private duty nursing agencies.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A private duty nursing agency could experience administrative cost associated with enrolling in the Medicaid Program. A home health agency which wishes to provide private duty nursing services could experience administrative costs associated with obtaining a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General as well as administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A private duty nursing agency that enrolls with the Medicaid Program and provide services to

Medicaid recipients in accordance with this administrative regulation will benefit by being reimbursed for the services. Likewise, a home health agency that takes the requisite steps will benefit by being reimbursed by the Medicaid Program for private duty nursing services.

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

(a) Initially: Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(b) On a continuing basis: Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

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

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions for Medicaid private duty nursing services and reimbursement.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396u-7(b) establishes the federal mandate regarding the Medicaid Program's coverage of private duty nursing services; however, there is no federal mandate to define Medicaid terms in an administrative regulation.

2. State compliance standards. KRS 194A.030(2) states, "The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act."

3. Minimum or uniform standards contained in the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation and Medicaid programs are not required to cover private duty nursing services; however, any Medicaid program which adds, to its eligible population, the "expansion group" authorized by the Affordable Care Act, must establish an alternative benefit plan for the expansion group. The expansion group is a new eligibility category comprised of adults below age sixty-five (65), with income below 133% of the federal poverty level, who are not pregnant, and who do not otherwise qualify for Medicaid. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent package." There are four (4) acceptable such packages as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit package provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit package the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick

and choose services from different alternative benefit plan options. The alternative benefit plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish an alternative benefit plan (plan of health care services covered) for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to have the same alternative benefit plan for the health benefit exchange as for the Medicaid expansion group. Kentucky selected an alternative benefit plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS is adopting the same benefit plan for all Medicaid recipients; thus, private duty nursing services will be covered for all Medicaid recipients who meet the coverage criteria. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation. As some home health agencies are owned by local governments, any such agency could be affected if it chooses to procure a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.80, 42 C.F.R. 440.330, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 is simply a definitions administrative regulation; however, the Department for Medicaid Services (DMS) is promulgating it in conjunction with two (2) other administrative regulations related to private duty nursing services. - 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services. DMS's coverage of private duty nursing services could generate revenue for some local governments as there are home health agencies in Kentucky owned by a local government entity. If any such entity elected to obtain a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program the entity could receive revenues in the form of Medicaid reimbursement for private duty nursing services. The revenues are indeterminable as the

Department for Medicaid Services cannot accurately predict how many such entities would take the requisite steps.

(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. The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.)

(d) How much will it cost to administer this program for subsequent years? Implementing this administrative regulation which establishes the definitions for KAR Chapter 13 creates no cost for DMS; however, DMS estimates that its annual cost associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds) 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:

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Administrative Regulation)

907 KAR 13:010. Private duty nursing service coverage provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.80, 440.330, 42 U.S.C. 1396u-7

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a 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 Medicaid Program coverage provisions and requirements regarding private duty nursing services.

Section 1. Provider Participation. (1) To be eligible to provide services under this administrative regulation, a provider shall be:

(a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(b) Except as established in subsection (2) of this section, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671; and

(c) 1. A private duty nursing agency; or

2. A home health agency licensed in accordance with 902 KAR 20:370 to provide private duty nursing services.

(2) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 2. Coverage and Limit. (1) The department shall reimburse for a private duty nursing service if the service is:

(a) Provided:

1. By a:

a. Registered nurse employed by a:

(i) Private duty nursing agency that meets the requirements

established in Section 3 of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section 3 of this administrative regulation; or

b. Licensed practical nurse employed by a:

(i) Private duty nursing agency that meets the requirements established in Section 3 of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section 3 of this administrative regulation;

2. To a recipient in the recipient's home, except as provided in subsection (2) of this section; and

3. Under the direction of the recipient's physician in accordance with 42 C.F.R. 440.80;

(b)1. Prescribed for the recipient by a physician; and

2. Stated in the recipient's plan of treatment developed by the prescribing physician;

(c) Established as being needed for the recipient in the recipient's home;

(d) Prior authorized; and

(e) Medically necessary.

(2) A private duty nursing service may be covered in a setting other than in the recipient's home, if the service is provided during a normal life activity of the recipient that requires the recipient to be out of his or her home.

(3)(a) There shall be an annual limit of private duty nursing services per recipient of 2,000 hours.

(b) The limit established in paragraph (a) of this subsection may be exceeded if services in excess of the limit are determined to be medically necessary.

Section 3. No Duplication of Service. The department shall not reimburse for any of the following services providing during the same time that a private duty nursing service is provided to a recipient:

(1) A personal care service;

(2) A skilled nursing service or visit; or

(3) A home health aide service.

Section 4. Conflict of Interest. The department shall not reimburse for a private duty nursing service provided to a recipient if the individual providing the service is:

(1) An immediate family member of the recipient; or

(2) A legally responsible individual who maintains his or her primary residence with the recipient.

Section 5. Records Maintenance, Protection, and Security.

(1)(a) A provider shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) A provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service.

(b) If the United States Department of Health and Human Services secretary requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A provider shall comply with 45 C.F.R. Part 164.

Section 6. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 7. Third Party Liability. A provider shall comply with KRS 205.622.

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 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, or 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. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 10. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 11. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office

of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the provisions and requirements regarding Medicaid Program private duty nursing services. These are new services being covered by the Department for Medicaid Services (DMS) resulting from DMS's implementation of an alternative benefit plan (based on a "benchmark" or "benchmark equivalent plan") as required by the Affordable Care Act. Any state which expands its Medicaid eligibility groups to include the "expansion group" authorized by the Affordable Care Act is required to establish an alternative benefit plan for the expansion group. The expansion group is comprised primarily of adults under age sixty-five (65) who are not pregnant, who have income below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid benefits. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The benchmark plan or benchmark equivalent plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish a benchmark plan or benchmark equivalent plan for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to use the same "benchmark" or "benchmark equivalent plan" as the health benefit exchange to establish the alternative benefit plan for the Medicaid expansion group. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS's benefit plan will be the same for all Medicaid recipients – existing populations as well as new eligibility groups authorized or mandated by the Affordable Care Act. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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

definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 13. Chapter 13 contains Medicaid administrative regulations regarding private duty nursing 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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: There are currently thirteen (13) private duty nursing agencies licensed in Kentucky and 109 home health agencies licensed 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. A private duty nursing agency that wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization. A home health agency that wishes to provide Medicaid-covered private duty nurse services must obtain a private duty nursing agency licensed from the Cabinet for Health and Family Services, Office of Inspector General in accordance with 902 KAR 20:370 and also enroll with the Medicaid Program as mentioned above for private duty nursing agencies.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A private duty nursing agency could experience administrative cost associated with enrolling in the Medicaid Program. A home health agency which wishes to provide private duty nursing services could experience administrative costs associated with obtaining a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General as well as administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A private duty nursing agency that enrolls with the Medicaid Program and provide services to Medicaid recipients in accordance with this administrative regulation will benefit by being reimbursed for the services. Likewise, a home health agency that takes the requisite steps will benefit by being reimbursed by the Medicaid Program for private duty nursing services.

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

(a) Initially: DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396u-7(b).

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. Medicaid programs are not required to cover private duty nursing services; however, any Medicaid program which adds, to its eligible population, the "expansion group" authorized by the Affordable Care Act, must establish an alternative benefit plan for the expansion group. The expansion group is a new eligibility category comprised of adults below age sixty-five (65), with income below 133% of the federal poverty level, who are not pregnant, and who do not otherwise qualify for Medicaid. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent package." There are four (4) acceptable such packages as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit package provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit package the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The alternative benefit plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish an alternative benefit plan (plan of health care services covered) for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to have the same alternative benefit plan for the health benefit exchange as for the Medicaid expansion group. Kentucky selected an alternative

benefit plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS is adopting the same benefit plan for all Medicaid recipients; thus, private duty nursing services will be covered for all Medicaid recipients who meet the coverage criteria.

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 the amendment to this administrative regulation. As some home health agencies are owned by local governments, any such agency could be affected if it chooses to procure a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.80, 42 C.F.R. 440.330, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 could generate revenue for some local governments as there are home health agencies in Kentucky owned by a local government entity. If any such entity elected to obtain a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program the entity could receive revenues in the form of Medicaid reimbursement for private duty nursing services. The revenues are indeterminable as the Department for Medicaid Services cannot accurately predict how many such entities would take the requisite steps.

(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. The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

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 Policy and Operations
(New Administrative Regulation)**

907 KAR 13:015. Private duty nursing service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

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 a 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 Department for Medicaid Services' reimbursement provisions and requirements regarding private duty nursing services.

Section 1. General Requirements. For the department to reimburse for a private duty nursing service under this administrative regulation, the:

(1) Provider shall meet the provider requirements established in 907 KAR 13:010; and

(2) The service shall meet the coverage and related requirements established in 907 KAR 13:010.

Section 2. Reimbursement. The department shall:

(1) Reimburse for private duty nursing services at a rate of nine (9) dollars per fifteen (15) minutes; and

(2) Not reimburse for more than:

(a) Ninety-six (96) units per recipient per twenty-four (24) hour period; or

(b) 8,000 units per twelve (12) consecutive month period per recipient.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for a service covered pursuant to 907 KAR 13:010 and this administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 19, 2013

FILED WITH LRC: December 26, 2013 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding private duty nursing services. These are new services being covered by the Department for Medicaid Services (DMS) resulting from DMS's implementation of an alternative benefit plan (based on a "benchmark" or "benchmark equivalent plan") as required by the Affordable Care Act. Any state which expands its Medicaid eligibility groups to include the "expansion group" authorized by the Affordable Care Act is required to establish an alternative benefit plan for the expansion group. The expansion group is comprised primarily of adults under age sixty-five (65) who are not pregnant, who have income below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid benefits. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit plan that the secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The benchmark plan or benchmark equivalent plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish a benchmark plan or benchmark equivalent plan for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to use the same "benchmark" or "benchmark equivalent plan" as the health benefit exchange to establish the alternative benefit plan for the Medicaid expansion group. Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS's benefit plan will be the same for all Medicaid recipients – existing populations as well as new eligibility groups authorized or mandated by the Affordable Care Act. DMS is promulgating this new administrative regulation in conjunction with two (2) accompanying private duty nursing service administrative regulations – 907 KAR 13:010, private duty nursing service coverage provisions and requirements and 907 KAR 13:015, reimbursement for private duty nursing services. DMS will reimburse for private duty nursing services at a rate of nine (9) dollars per fifteen (15) minute unit and services will be limited to no more than ninety-six (96) units per twenty-four (24) hour period and 8,000 units per twelve (12) consecutive months.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish reimbursement for private duty nursing services which are being added to DMS's array of covered services via companion administrative regulations - 907 KAR 13:005, Definitions for 907 KAR Chapter 13 and 907 KAR 13:010, Private duty nursing service coverage provisions and requirements. DMS is added private duty nursing services to its cope of covered services as explained in paragraph (a) above.

(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 complying with the Affordable Care Act.

(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 complying with the Affordable Care Act.

(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 rather than an amendment to an existing administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation rather than an amendment to an existing administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation rather than 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: There are currently thirteen (13) private duty nursing agencies licensed in Kentucky and 109 home health agencies licensed 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. A private duty nursing agency that wishes to provide services to Medicaid recipients and be reimbursed by DMS for the services will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization. A home health agency that wishes to provide Medicaid-covered private duty nurse services must obtain a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General in accordance with 902 KAR 20:370 and also enroll with the Medicaid Program as mentioned above for private duty nursing agencies.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). A private duty nursing agency could experience administrative cost associated with enrolling in the Medicaid Program. A home health agency which wishes to provide private duty nursing services could experience administrative costs associated with obtaining a private duty nursing agency license from the Cabinet for Health and Family Services, Office of Inspector General as well as administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). A private duty nursing agency that enrolls with the Medicaid Program and provide services to Medicaid recipients in accordance with this pursuant to this administrative regulation. DMS is establishing a rate of nine (9) dollars per fifteen (15) minute unit for private duty nursing services. Likewise, a home health agency that takes the requisite steps will

benefit by being reimbursed by the Medicaid Program for private duty nursing services at the aforementioned rate.

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

(a) Initially: DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396u-7(b), 42 U.S.C. 1396a(a)(30), and 42 C.F.R. 447.204.

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. Medicaid programs are not required to cover private duty nursing services; however, any Medicaid program which adds, to its eligible population, the "expansion group" authorized by the Affordable Care Act, must establish an alternative benefit plan for the expansion group. The expansion group is a new eligibility category comprised of adults below age sixty-five (65), with income below 133 percent of the federal poverty level, who are not pregnant, and who do not otherwise qualify for Medicaid. An alternative benefit plan has to be based on a "benchmark" or "benchmark-equivalent package." There are four (4) acceptable such packages as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are: The benefit package provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option; The state employer health coverage that is offered and generally available to state employees; The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and Secretary-approved coverage, which is a benefit package the secretary has determined to provider coverage appropriate to meet the needs of the population provided that coverage. States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options. The alternative benefit plan is also the plan for the state's health benefit exchange. A health benefit exchange (also referred to as a health insurance exchange or "affordable insurance exchange") is mandated for each state by the Affordable Care Act. The health benefit exchange is a marketplace of health insurance plans. Individuals whose income is within the threshold of qualifying to

purchase health insurance through the health benefit exchange can do so and the government will help subsidize the cost of the individual's health insurance premiums. Each state is required to establish an alternative benefit plan (plan of health care services covered) for its health benefit exchange. States who add the Medicaid expansion group, authorized by the Affordable Care Act, to its Medicaid Program coverage are required to have the same alternative benefit plan for the health benefit exchange as for the Medicaid expansion group. Kentucky selected an alternative benefit plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan includes private duty nursing services as a benefit, DMS is required to cover private duty nursing services. DMS is adopting the same benefit plan for all Medicaid recipients; thus, private duty nursing services will be covered for all Medicaid recipients who meet the coverage criteria. 42 U.S.C. 1396a(a)(30) requires Medicaid program payments to be consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the same geographic area. 42 C.F.R. 447.204 requires Medicaid reimbursement to be sufficient to enlist enough providers to ensure that services are available to Medicaid recipients at least to the extent that they are available to the general population.

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 the amendment to this administrative regulation. As some home health agencies are owned by local governments, any such agency could be affected if it chooses to procure a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 440.80, 42 C.F.R. 440.330, and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is 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 could generate revenue for some local governments as there are home health agencies in Kentucky owned by a local government entity. If any such entity elected to obtain a private duty nursing license from the Cabinet for Health and Family Services, Office of Inspector General and enroll with the Medicaid Program the entity could receive revenues in the form of Medicaid reimbursement for private duty nursing services. The revenues are indeterminable as the Department for Medicaid Services cannot accurately predict how many such entities would take the requisite steps.

(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. The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS estimates that its cost associated with covering private duty nursing services will be \$12.87 million (\$2.44 million in state funds and \$10.43 million in federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that its annual cost, beginning with state fiscal year 2015, associated with covering private duty nursing services will be \$17.17 million (\$3.26 million in state funds and \$13.91 million in federal funds.)

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

CABINET FOR HEALTH AND FAMILY SERVICES Department for Medicaid Services Commissioner's Office (New Administrative Regulation)

907 KAR 15:005. Definitions for 907 KAR Chapter 15.

RELATES TO: 194A.025(3)

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

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. This administrative regulation establishes the definitions for 907 KAR Chapter 15.

Section 1. Definitions. (1) "Advanced practice registered nurse" is defined by KRS 314.011(7).

(2) "Billing provider" means the individual or entity who:

(a) Is authorized to bill the department or a managed care organization for a service; and

(b) Is eligible to be reimbursed by the department or a managed care organization for a service.

(3) "Certified social worker" means an individual who:

(a) Meets the requirements established in KRS 335.080; and

(b) Has at least a master's degree in social work.

(4) "Community support associate" means an individual who meets the community support associate requirements established in 908 KAR 2:250.

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

(6) "Electronic signature" is defined by KRS 369.102(8).

(7) "Enrollee" means a recipient who is enrolled with a managed care organization.

(8) "Face-to-face" means occurring:

(a) In person; or

(b) Via a real-time, electronic communication that involves two (2)-way interactive video and audio communication.

(9) "Family peer support specialist" means an individual who meets the requirements for a Kentucky family peer support specialist established in 908 KAR 2:230.

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

(11) "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(12) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(13) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(14) "Licensed professional counselor associate" is defined by

KRS 335.500(3).

(15) "Licensed psychological associate" means an individual who:

(a) Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychological associate requirements established in 201 KAR Chapter 26.

(16) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(17) "Licensed psychologist" means an individual who:

(a) Currently possesses a licensed psychologist license in accordance with KRS 319.010(6); and

(b) Meets the licensed psychologist requirements established in 201 KAR Chapter 26.

(18) "Managed care organization" 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.

(19) "Marriage and family therapy associate" is defined by KRS 335.300(3).

(20) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(21) "Peer support specialist" means an individual who meets the peer specialist qualifications established in 908 KAR 2:220.

(22) "Physician" is defined by KRS 205.510(11) and 42 C.F.R. 405.2401(b).

(23) "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(24) "Provider" is defined by KRS 205.8451(7).

(25) "Provider abuse" is defined by KRS 205.8451(8).

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

(27) "Recipient abuse" is defined by KRS 205.8451(10).

(28) "Registered nurse" is defined by KRS 314.011(5).

(29) "Youth peer support specialist" means an individual who meets the requirements established for a Kentucky youth peer support specialist established in 908 KAR 2:240.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independently enrolled providers (such as a

licensed psychologist, licensed professional clinical counselor, licensed clinical social worker, licensed psychological practitioner, licensed marriage and family therapist) rather than agency behavioral health service providers (such as a community mental health center, federally qualified health center, or rural health clinic.)

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independent providers. The Department for Medicaid Services (DMS) is expanding its scope of behavioral health service coverage to include substance use disorder services as a result of an Affordable Care Act mandate for Medicaid programs to cover such services for all Medicaid recipients. Currently, DMS covers such services for pregnant women and children.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independent providers.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the definitions for administrative regulations located in 907 KAR Chapter 15. Chapter 15 contains Medicaid administrative regulations regarding behavioral health services, including substance use disorder services, provided by independent providers.

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

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients of behavioral health services (including substance use disorder services) and independent behavioral health service providers (including substance use disorder service providers) will be affected by the administrative regulation.

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

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

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Individuals will benefit due to terms being defined.

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

(a) Initially: No cost is necessary to initially implement this administrative regulation.

(b) On a continuing basis: No continuing cost is necessary to implement this administrative regulation.

(6) What is the source of the funding to be used for the

implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds comprised of general fund and restricted fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

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

(9) Tiering: Is tiering applied? Tiering is neither applied nor necessary as the administrative regulation establishes definitions for Medicaid independent behavioral health services (including substance use disorder services) and reimbursement.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

2. State compliance standards. KRS 194A.030(2) states, "The Department for Medicaid Services shall serve as the single state agency in the Commonwealth to administer Title XIX of the Federal Social Security Act."

3. Minimum or uniform standards contained in the federal mandate. There is no federal mandate to define Medicaid terms in an administrative regulation; however, Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

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. Stricter requirements are not imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

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? None.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.

(c) How much will it cost to administer this program for the first year? No cost is necessary to implement this administrative regulation in the first year.

(d) How much will it cost to administer this program for subsequent years? No cost is necessary in subsequent years to implement this administrative regulation.

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

Revenues (+/-): .

Expenditures (+/-):

Other explanation:

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(New Administrative Regulation)

907 KAR 15:010. Coverage provisions and requirements regarding behavioral health services provided by independent providers.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

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 a 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 coverage provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program or practitioners working for or under the supervision of the independent providers.

Section 1. General Coverage Requirements. (1) For the department to reimburse for a service covered under this administrative regulation, the service shall be:

(a) Medically necessary;

(b) Provided:

1. To a recipient; and

2. By a:

a. Provider who meets the provider participation requirements established in Section 2 of this administrative regulation; or

b. Practitioner working under the supervision of a provider who meets the provider participation requirements established in Section 2 of this administrative regulation; and

(c) Billed to the department by the billing provider who provided the service or under whose supervision the service was provided by an authorized practitioner in accordance with Section 3 of this administrative regulation.

(2)(a) Direct contact between a provider or practitioner and a recipient shall be required for each service except for a collateral service for a child under the age of twenty-one (21) years if the collateral service is in the child's plan of care.

(b) A service that does not meet the requirement in paragraph

(a) of this subsection shall not be covered.

(3) A billable unit of service shall be actual time spent delivering a service in a face-to-face encounter.

(4) A service shall be:

(a) Stated in a recipient's treatment plan; and

(b) Provided in accordance with a recipient's treatment plan;

(c) Provided on a regularly scheduled basis except for a screening or assessment; and

(d) Made available on a nonscheduled basis if necessary during a crisis or time of increased stress for the recipient.

Section 2. Provider Participation. (1) To be eligible to provide services under this administrative regulation a provider shall:

(a) Be currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

(b) Except as established in subsection (2) of this section, be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(2) In accordance with 907 KAR 17:010, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

(3) A provider shall:

(a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability; and

(b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the Act.

Section 3. Covered Services. (1) Except as specified in the requirements stated for a given service, the services covered may be provided for a:

(a) Mental health disorder;

(b) Substance use disorder; or

(c) Co-occurring mental health and substance use disorder.

(2) The following shall be covered under this administrative regulation in accordance with the corresponding following requirements:

(a) A screening provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(b) An assessment provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(c) Psychological testing provided by:

1. A licensed psychologist;

2. A licensed psychological practitioner; or

3. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

(d) Crisis intervention provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service; or

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(e) Service planning provided by:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the

supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. Peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional; or

16. A youth peer support specialist working under the supervision of a mental health professional;

(m) Comprehensive community support services provided by a team of at least two (2) of the following:

1. A licensed psychologist;

2. A licensed professional clinical counselor;

3. A licensed clinical social worker;

4. A licensed marriage and family therapist;

5. A physician;

6. A psychiatrist;

7. An advanced practice registered nurse;

8. A licensed psychological practitioner;

9. A licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

11. A certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

14. A peer support specialist working under the supervision of a mental health professional;

15. A family peer support specialist working under the supervision of a mental health professional;

16. A youth peer support specialist working under the supervision of a mental health professional; or

17. A community support associate;

(n) Peer support provided by:

1. A peer support specialist working under the supervision of a mental health professional;

2. A family peer support specialist working under the supervision of a mental health professional; or

3. A youth peer support specialist working under the supervision of a mental health professional; or

(o) Parent or family peer support provided by:

1. A peer support specialist working under the supervision of a mental health professional;

2. A family peer support specialist working under the supervision of a mental health professional; or

3. A youth peer support specialist working under the supervision of a mental health professional.

(3)(a) A screening shall:

1. Be the determination of the likelihood that an individual has a mental health disorder, substance use disorder, or co-occurring disorder;

2. Not establish the presence or specific type of disorder; and

3. Establish the need for an in-depth assessment.

(b) An assessment shall:

1. Include gathering information and engaging in a process with the individual that enables the provider to:

a. Establish the presence or absence of a mental health disorder or substance use disorder;

b. Determine the individual's readiness for change;

c. Identify the individual's strengths or problem areas that may affect the treatment and recovery processes; and

d. Engage the individual in developing an appropriate treatment relationship;

2. Establish or rule out the existence of a clinic disorder or service need;

3. Including working with the individual to develop a treatment and service plan; and

4. Not include psychological or psychiatric evaluations or assessments.

(c) Psychological testing shall include:

1. A psychodiagnostic assessment of personality, psychopathology, emotionality, or intellectual disabilities; and

2. Interpretation and a written report of testing results.

(d) Crisis intervention:

1. Shall be a therapeutic intervention for the purpose of immediately reducing or eliminating the risk of physical or emotional harm to:

a. The recipient; or

b. Another individual;

2. Shall consist of clinical intervention and support services necessary to provide integrated crisis response, crisis stabilization interventions, or crisis prevention activities for individuals with behavioral health disorders;

3. Shall be provided:

a. In an office, home, or community setting where the individual is experiencing the crisis;

b. As an immediate relief to the presenting problem or threat; and

c. In a face-to-face, one-on-one encounter between the provider and the recipient;

4. May include verbal de-escalation, risk assessment, or cognitive therapy; and

5. Shall be followed by a referral to noncrisis services if applicable.

(e)1. Service planning shall consist of assisting a recipient in creating an individualized plan for services needed to maintain functional stability or return to stability as soon as possible in order to avoid out-of-home care.

2. A service plan:

a. Shall be directed by the recipient; and

b. May include:

(i) A mental health advance directive being filed with a local hospital;

(ii) A crisis plan; or

(iii) A relapse prevention strategy or plan.

(f) Individual outpatient therapy shall:

1. Be provided to promote the:

a. Health and wellbeing of the individual; or

b. Recovery from a substance related disorder;

2. Consist of:

a. A face-to-face, one-on-one encounter between the provider and recipient; and

b. A behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

3. Be aimed at:

a. Reducing adverse symptoms;

b. Reducing or eliminating the presenting problem of the recipient; and

c. Improving functioning; and

4. Not exceed three (3) hours per day.

(g)1. Family outpatient therapy shall consist of a face-to-face behavioral health therapeutic intervention provided:

a. Through scheduled therapeutic visits between the therapist and the recipient and at least one (1) member of the recipient's family; and

b. To address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment.

2. A family outpatient therapy session shall be billed as one (1) service regardless of the number of individuals (including multiple members from one (1) family) who participate in the session.

(h)1. Group outpatient therapy shall:

a. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Recovery from a substance related disorder;

b. Consist of a face-to-face behavioral health therapeutic intervention provided in accordance with the recipient's identified treatment plan;

c. Be provided to a recipient in a group setting:

(i) Of nonrelated individuals; and

(ii) Not to exceed eight (8) individuals in size;

d. Center on goals including building and maintaining healthy relationships, personal goals setting, and the exercise of personal judgment;

e. Not include physical exercise, a recreational activity, an educational activity, or a social activity; and

f. Not exceed three (3) hours per day.

2. The group shall have a:

a. Deliberate focus; and

b. Defined course of treatment.

3. The subject of a group receiving group outpatient therapy shall be related to each recipient participating in the group.

4. The provider shall keep individual notes regarding each recipient within the group and within each recipient's health record.

(i)1. Collateral outpatient therapy shall:

a. Consist of a face-to-face behavioral health consultation:

(i) With a parent or caregiver of a recipient, household member of a recipient, legal representative of a recipient, school personnel, treating professional, or other person with custodial control or supervision of the recipient; and

(ii) That is provided in accordance with the recipient's treatment plan; and

b. Not be reimbursable if the therapy is for a recipient who is at least twenty-one (21) years of age.

2. Consent to discuss a recipient's treatment with any person other than a parent or legal guardian shall be signed and filed in the recipient's health record.

(j) Screening, brief intervention, and referral to treatment for a substance use disorder shall:

1. Be an evidence-based early intervention approach for an individual with non-dependent substance use to provide an effective strategy for intervention prior to the need for more extensive or specialized treatment; and

2. Consist of:

a. Using a standardized screening tool to assessing an individual for risky substance use behavior;

b. Engaging a recipient, who demonstrates risky substance use behavior, in a short conversation and providing feedback and advice; and

c. Referring a recipient to:

(i) Therapy; or

(ii) Other additional services to address substance use if the recipient is determined to need other additional services.

(k) Medication assisted treatment for a substance use disorder:

1. Shall include:

a. Any opioid addiction treatment that includes a United States Food and Drug Administration-approved medication for the detoxification or maintenance treatment of opioid addiction along with counseling or other supports;

b. Comprehensive maintenance;

c. Medical maintenance;

d. Interim maintenance;

e. Detoxification; or

f. Medically supervised withdrawal;

2. May be provided in:

a. An opioid treatment program;

b. A medication unit affiliated with an opioid treatment program;

c. A physician's office; or

d. Other community setting; and

3. Shall increase the likelihood for cessation of illicit opioid use or prescription opioid abuse.

(l)1. Day treatment shall be a nonresidential, intensive treatment program designed for a child under the age of twenty-one (21) years who has:

a. An emotional disability or neurobiological or substance use disorder; and

b. A high risk of out-of-home placement due to a behavioral health issue.

2. Day treatment services shall:

a. Consist of an organized, behavioral health program of treatment and rehabilitative services (substance use disorder, mental health, or co-occurring mental health and substance use disorder);

b. Have unified policies and procedures that:

(i) Address the program philosophy, admission and discharge criteria, admission and discharge process, staff training, and integrated case planning; and

(ii) Have been approved by the recipient's local education authority and the day treatment provider;

c. Include:

(i) Individual outpatient therapy, family outpatient therapy, or group outpatient therapy;

(ii) Behavior management and social skill training;

(iii) Independent living skills that correlate to the age and development stage of the recipient; or

(iv) Services designed to explore and link with community resources before discharge and to assist the recipient and family with transition to community services after discharge; and

d. Be provided:

(i) In collaboration with the education services of the local education authority including those provided through 20 U.S.C. 1400 et seq. (Individuals with Disabilities Education Act) or 29 U.S.C. 701 et seq. (Section 504 of the Rehabilitation Act);

(ii) On school days and during scheduled breaks;

(iii) In coordination with the recipient's individual educational plan if the recipient has an individual educational plan;

(iv) Under the supervision of a licensed or certified behavioral health practitioner or a behavioral health practitioner working under clinical supervision; and

(v) With a linkage agreement with the local education authority that specifies the responsibilities of the local education authority and the day treatment provider.

3. To provide day treatment services, a provider shall have:

a. The capacity to employ staff authorized to provide day treatment services in accordance with subsection (2)(l) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of residential crisis stabilization services as stated in subparagraph 1 of this paragraph;

c. Demonstrated experience in serving individuals with behavioral health disorders;

d. The administrative capacity to ensure quality of services;

e. A financial management system that provides documentation of services and costs;

f. The capacity to document and maintain individual case records; and

g. Knowledge of substance use disorders.

4. Day treatment shall not include a therapeutic clinical service that is included in a child's individualized education plan.

(m)1. Comprehensive community support services shall:

a. Be activities necessary to allow an individual to live with maximum independence in community-integrated housing;

b. Be intended to ensure successful community living through the utilization of skills training, cueing, or supervision as identified in the recipient's treatment plan;

c. Include:

(i) Reminding a recipient to take medications and monitoring symptoms and side effects of medications; or

(ii) Teaching parenting skills, teaching community resource access and utilization, teaching emotional regulation skills,

teaching crisis coping skills, teaching how to shop, teaching about transportation, teaching financial management, or developing and enhancing interpersonal skills; and

c. Meet the requirements for comprehensive community support services established in 908 KAR 2:250.

3. To provide comprehensive community support services, a provider shall have:

a. The capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (2)(m) of this section and to coordinate the provision of services among team members;

b. The capacity to provide the full range of comprehensive community support services as stated in this subparagraph 1 of this paragraph;

c. Demonstrated experience in serving individuals with behavioral health disorders;

d. The administrative capacity to ensure quality of services;

e. A financial management system that provides documentation of services and costs; and

f. The capacity to document and maintain individual case records.

(n)1. Peer support services shall:

a. Be social and emotional support that is provided by an individual who is experiencing a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a recipient by sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified consumer or parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:220;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide peer support services a provider shall:

a. Have demonstrated the capacity to provide the core elements of peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ peer support specialists who are qualified to provide peer support services in accordance with 908 KAR 2:220;

c. Use a qualified mental health professional to supervise peer support specialists;

d. Have the capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (2)(n) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of comprehensive community support services as stated in this subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(o)1. Parent or family peer support services shall:

a. Be emotional support that is provided by a parent or family member of a child who is experiencing a mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder to a parent or family member with a child sharing a similar mental health disorder, substance use disorder, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change;

b. Be an evidence-based practice;

c. Be structured and scheduled nonclinical therapeutic activities with an individual recipient or a group of recipients;

d. Be provided by a self-identified parent or family member of a child consumer of mental health disorder services, substance use disorder services, or co-occurring mental health disorder services and substance use disorder services who has been trained and certified in accordance with 908 KAR 2:230;

e. Promote socialization, recovery, self-advocacy, preservation, and enhancement of community living skills for the recipient; and

f. Be identified in each recipient's treatment plan.

2. To provide parent or family peer support services a provider shall:

a. Have demonstrated the capacity to provide the core elements of parent or family peer support services for the behavioral health population being served including the age range of the population being served;

b. Employ family peer support specialists who are qualified to provide family peer support services in accordance with 908 KAR 2:230;

c. Use a qualified mental health professional to supervise family peer support specialists;

d. Have the capacity to employ staff authorized to provide comprehensive community support services in accordance with subsection (2)(n) of this section and to coordinate the provision of services among team members;

e. Have the capacity to provide the full range of comprehensive community support services as stated in this subparagraph 1 of this paragraph;

f. Have demonstrated experience in serving individuals with behavioral health disorders;

g. Have the administrative capacity to ensure quality of services;

h. Have a financial management system that provides documentation of services and costs; and

i. Have the capacity to document and maintain individual case records.

(4)(a) The following requirements shall apply to any provider of a service to a recipient for a substance use disorder or co-occurring mental health disorder and substance use disorder:

1. The licensing requirements established in 908 KAR 1:370;

2. The physical plant requirements established in 908 KAR 1:370;

3. The organization and administration requirements established in 908 KAR 1:370;

4. The personnel policy requirements established in 908 KAR 1:370;

5. The quality assurance requirements established in 908 KAR 1:370;

6. The clinical staff requirements established in 908 KAR 1:370;

7. The program operational requirements established in 908 KAR 1:370; and

8. The outpatient program requirements established in 908 KAR 1:370.

(b) The detoxification program requirements established in 908 KAR 1:370 shall apply to a provider of a detoxification service.

(5) The extent and type of assessment performed at the time of a screening shall depend upon the problem of the individual seeking or being referred for services.

(6) A diagnosis or clinic impression shall be made using terminology established in the most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(7) The department shall not reimburse for a service billed by or on behalf of an entity or individual who is not a billing provider.

Section 4. Noncovered Services or Activities. (1) The following services or activities shall not be covered under this administrative regulation:

(a) A service provided to:

1. A resident of:

- a. A nursing facility; or
- b. An intermediate care facility for individuals with an intellectual disability;
- 2. An inmate of a federal, local, or state:
 - a. Jail;
 - b. Detention center; or
 - c. Prison;
- 3. An individual with an intellectual disability without documentation of an additional psychiatric diagnosis;
 - (b) Psychiatric or psychological testing for another agency, including a court or school, that does not result in the individual receiving psychiatric intervention or behavioral health therapy from the independent provider;
 - (c) A consultation or educational service provided to a recipient or to others;
 - (d) Collateral therapy for an individual aged twenty-one (21) years or older;
 - (e) A telephone call, an email, a text message, or other electronic contact that does not meet the requirements stated in the definition of "face-to-face";
 - (f) Travel time;
 - (g) A field trip;
 - (h) A recreational activity;
 - (i) A social activity; or
 - (j) A physical exercise activity group.
- (2)(a) A consultation by one (1) provider or professional with another shall not be covered under this administrative regulation except as specified in Section 3(3)(k) of this administrative regulation.
- (b) A third party contract shall not be covered under this administrative regulation.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independent behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a local health department.

Section 6. Records Maintenance, Documentation, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2)(a) A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(b) The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(3) A health record shall:

(a) Include:

1. An identification and intake record including:

- a. Name;
- b. Social Security number;
- c. Date of intake;
- d. Home (legal) address;
- e. Health insurance information;
- f. Referral source and address of referral source;
- g. Primary care physician and address;
- h. The reason the individual is seeking help including the presenting problem and diagnosis; and

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider;

k. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

- (i) This administrative regulation;
- (ii) The provider's licensure board;

- (iii) State law; or
- (iv) Federal law;
- 2. Documentation of the:
 - a. Screening;
 - b. Assessment;
 - c. Disposition; and
 - d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs; and
- 3. A complete history including mental status and previous treatment;
- 4. An identification sheet;
- 5. A consent for treatment sheet that is accurately signed and dated; and
- 6. The individual's stated purpose for seeking services.
- (b) Be:
 - 1. Maintained in an organized central file;
 - 2. Furnished to the Cabinet for Health and Family Services upon request;
 - 3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;
 - 4. Readily accessible;
 - 5. Adequate for the purpose establishing the current treatment modality and progress of the recipient;
- (4) Documentation of a screening shall include:
 - (a) Information relative to the individual's stated request for services; and
 - (b) Other stated personal or health concerns if other concerns are stated.
- (5)(a) A provider's notes regarding a recipient shall:
 - 1. Be made within forty-eight (48) hours of each service visit;
 - 2. Describe the:
 - a. Recipient's symptoms or behavior, reaction to treatment, and attitude;
 - b. Therapist's intervention;
 - c. Changes in the treatment plan if changes are made; and
 - d. Need for continued treatment if continued treatment is needed.
- (b)1. Any edit to notes shall:
 - a. Clearly display the changes;
 - b. Be initialed and dated.
- 2. Notes shall not be erased or illegibly marked out.
- (c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by the supervising professional providing the service.
- 2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervision professional reflecting consultations with the practitioner working under supervision concerning the:
 - a. Case; and
 - b. Supervising professional's evaluation of the services being provided to the recipient.
- (6) Immediately following a screening of a recipient, the provider shall perform a disposition related to:
 - (a) An appropriate diagnosis;
 - (b) A referral for further consultation and disposition, if applicable; and
- (c)1. Termination of services and referral to an outside source for further services; or
- 2. Termination of services without a referral to further services.
- (7)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.
- (b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.
- (8)(a) Notes regarding services to a recipient shall:
 - 1. Be organized in chronological order;
 - 2. Dated;
 - 3. Titled to indicate the service rendered;
 - 4. State a starting and ending time for the service; and
 - 5. Be recorded and signed by the rendering provider and included the professional title (for example, licensed clinical social worker) of the provider.
- (b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other non-reimbursable contacts shall:

1. Be recorded in the notes; and
2. Not be reimbursable.

(9) A termination summary shall:

(a) Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

(b) Contain a summary of the significant findings and events during the course of treatment including the:

1. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

2. Final diagnosis of clinical impression;

3. Individual's condition upon termination and disposition.

(c) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(10) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(11) If a recipient is transferred or referred to a health care facility or other provider for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient.

(12)(a) If a provider's Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records of the provider shall:

1. Remain the property of the provider; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A provider shall have a written plan addressing how to maintain health records in the event of the provider's death.

(13)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(14)(a) A provider shall comply with 45 C.F.R. Chapter 164.

(b) All information contained in a health record shall be:

1. Treated as confidential;
2. Not be disclosed to an unauthorized individual;
3. Be disclosed to an authorized representative of:
 - a. The department; or
 - b. Federal government;

(c)1. Upon request, a provider shall provide to an authorized representative of the department or federal government information requested to substantiate:

a. Staff notes detailing a service that was rendered;

b. The professional who rendered a service;

c. The type of service rendered and any other requested information necessary to determine, on an individual basis, whether the service is reimbursable by the department.

2. Failure to provide information referenced in subparagraph 1 of this paragraph shall result in denial of payment for any service associated with the requested information.

Section 7. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the

provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(3)(a) When the department makes payment for a covered service and the provider accepts the payment:

1. The payment shall be considered payment in full;

2. No bill for the same service shall be given to the recipient; and

3. No payment from the recipient for the same service shall be accepted by the provider.

(b)1. A provider may bill a recipient for a service that is not covered by the Kentucky Medicaid Program if the:

a. Recipient requests the service; and

b. Provider makes the recipient aware in advance of providing the service that the:

(i) Recipient is liable for the payment; and

(ii) Department is not covering the service.

2. If a recipient makes payment for a service in accordance with subparagraph 1 of this paragraph, the:

a. Provider shall not bill the department for the service; and

b. Department shall not:

(i) Be liable for any part of the payment associated with the service; and

(ii) Make any payment to the provider regarding the service.

(4)(a) A provider attests by the provider's signature that any claim associated with a service is valid and submitted in good faith.

(b) Any claim and substantiating record associated with a service shall be subject to audit by the:

1. Department or its designee;

2. Cabinet for Health and Family Services, Office of Inspector General or its designee;

3. Kentucky Office of Attorney General or its designee;

4. Kentucky Office of the Auditor for Public Accounts or its designee;

5. United States General Accounting Office or its designee;

(c) If a provider receives a request from the department to provide a claim or related information or related documentation or record for Medicaid RAC Program purposes, the provider shall provide the request information to the department within the timeframe requested by the department.

(d)1. All services provided shall be subject to review for recipient or provider abuse.

2. Willful abuse by a provider shall result in the suspension or termination of the provider from Medicaid Program participation.

Section 8. Third Party Liability. A provider shall comply with KRS 205.622.

Section 9. 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 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, or 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 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 10. Auditing Authority. The department shall have the authority to audit any:

- (1) Claim;
- (2) Medical record; or
- (3) Documentation associated with any claim or medical record.

Section 11. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the coverage; and
- (2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 12. Appeals. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program as Medicaid providers or practitioners working for or under the supervision of the independent provides. This administrative regulation is being promulgated in conjunction with two (2) administrative regulations – 907 KAR 15:015 (Reimbursement for behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for 907 KAR Chapter 15). Currently, the Department for Medicaid Services does not enroll licensed psychologists, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, or licensed psychological practitioners as independent Medicaid providers. Rather these providers have to work for or under contract with - for example - a community mental health center, a physician's office, a federally-

qualified health center, or a rural health clinic among other entities and the entity bills (and is reimbursed by) the Medicaid Program for the services provided. This administrative regulation also establishes practitioners who may provide behavioral health services under supervision of one (1) of the aforementioned independent providers and in which case the Medicaid Program will reimburse the independent provider (billing provider) for the services.

(b) The necessity of this administrative regulation: This administrative regulation is being promulgated in conjunction with two (2) administrative regulations – 907 KAR 15:015 (Reimbursement for behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for KAR Chapter 15) - to comply with a federal mandate and to enhance recipient access to services. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients. Currently, DMS covers substance use treatment for pregnant women and children. Additionally, this administrative regulation is necessary to enhance Medicaid recipient access to behavioral health services by expanding the providers and practitioners authorized to provide the services as independent providers or as practitioners working under the supervision of an independent provider. The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 complying with a federal mandate and by enhancing and ensuring Medicaid recipients' access to behavioral health 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 authorizing statutes by complying with a federal mandate and by enhancing and ensuring Medicaid recipients' access to behavioral health 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: Licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, and licensed psychological practitioners who wish to enroll in the Medicaid Program as independent providers will be affected by this administrative regulation. Licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and

family therapy associates who wish to provide behavioral health services while working for one (1) of the aforementioned independent providers will also be affected by this administrative regulation. Medicaid recipients who qualify for behavioral health services will be affected by this 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. Individuals listed in question (3) who wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Individuals who wish to provide behavioral health services to Medicaid recipients per this administrative regulation could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An individual who enrolls with the Medicaid Program to provide behavioral health services will benefit by being reimbursed for services provided to Medicaid recipients. Behavioral health service practitioners who can work for an independent behavioral health service provider will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive these services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)

(b) On a continuing basis: The response to question (a) also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), and 42 U.S.C. 1396a(a)(23).

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. Substance use disorder services are federally mandated for Medicaid programs. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area.

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 the amendment to 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 is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved

as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)

(d) How much will it cost to administer this program for subsequent years? The response to question (a) also applies here.

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 Policy and Operations
(New Administrative Regulation)

907 KAR 15:015. Reimbursement provisions and requirements for behavioral health services provided by independent providers.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23)

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 a 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 provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program as Medicaid providers, or behavioral health service practitioners working for or under supervision of the independent behavioral health service providers, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. For the department to reimburse for a service covered under this administrative regulation, the service shall be:

(1) Medically necessary;

(2) Provided:

(a) To a recipient; and

(b) By a:

1. Provider who meets the provider participation requirements established in 907 KAR 15:010; or

2. Practitioner working under the supervision of a provider who meets the provider participation requirements established in 907 KAR 15:010;

(3) A service covered in accordance with 907 KAR 15:010; and

(4) Billed to the department by the billing provider who provided the service or under whose supervision the service was provided by an authorized practitioner in accordance with 907 KAR 15:010.

Section 2. Reimbursement. (1) One (1) unit of service shall be fifteen (15) minutes in length or the unit amount identified in the corresponding current procedural terminology code.

(2) The rate per unit for a screening shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(3) The rate per unit for an assessment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(4) The rate per unit for psychological testing shall be:

(a) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychologist;

(b) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychological practitioner; or

(c) Fifty-two and five-tenths (52.5) percent of the rate on the

Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service.

(5) The rate per unit for screening, brief intervention, and referral to treatment shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or
2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or
2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;
2. Licensed clinical social worker;
3. Licensed psychological practitioner; or
4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(6) The rate per unit for crisis intervention shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or
2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or
2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;
2. Licensed clinical social worker;
3. Licensed psychological practitioner; or
4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health professional.

(7) The rate per unit for service planning shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or
2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or
2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;
2. Licensed clinical social worker;
3. Licensed psychological practitioner; or
4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service; or

5. Physician assistant working for a physician if the physician is the billing provider for the service.

(8) The rate per unit for individual outpatient therapy shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or
2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or
2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;
2. Licensed clinical social worker;
3. Licensed psychological practitioner; or
4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health professional.

(14) The rate per unit for comprehensive community support services shall be:

(a) Seventy-five (75) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Physician; or

2. Psychiatrist;

(b) 63.75 percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by:

1. An advanced practice registered nurse; or

2. A licensed psychologist;

(c) Sixty (60) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Licensed professional clinical counselor;

2. Licensed clinical social worker;

3. Licensed psychological practitioner; or

4. Licensed marriage and family therapist; or

(d) Fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

1. Marriage and family therapy associate working under the supervision of a licensed marriage and family therapist if the licensed marriage and family therapist is the billing provider for the service;

2. Licensed professional counselor associate working under the supervision of a licensed professional clinical counselor if the licensed professional clinical counselor is the billing provider for the service;

3. Licensed psychological associate working under the supervision of a licensed psychologist if the licensed psychologist is the billing provider for the service;

4. Certified social worker working under the supervision of a licensed clinical social worker if the licensed clinical social worker is the billing provider for the service;

5. Physician assistant working for a physician if the physician is the billing provider for the service;

6. Peer support specialist working under the supervision of a mental health professional;

7. Family peer support specialist working under the supervision of a mental health professional; or

8. Youth peer support specialist working under the supervision of a mental health professional.

(15) The rate per unit for peer support services shall be fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

(a) Peer support specialist working under the supervision of a mental health professional;

(b) Family peer support specialist working under the supervision of a mental health professional; or

(c) Youth peer support specialist working under the supervision of a mental health professional.

(16) The rate per unit for parent or family peer support services shall be fifty-two and five-tenths (52.5) percent of the rate on the Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a:

(a) Peer support specialist working under the supervision of a mental health professional;

(b) Family peer support specialist working under the supervision of a mental health professional; or

(c) Youth peer support specialist working under the supervision of a mental health professional.

(17) The department shall not reimburse for a service billed by or on behalf of an entity or individual that is not a billing provider.

Section 3. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a behavioral health service from an independent behavioral health provider, the department shall not reimburse for the same service provided to the same recipient during the same time period by a community mental health center.

Section 4. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 15:010; and

(2) This administrative regulation.

Section 5. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

LAWRENCE KISSNER, Commissioner

AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: December 26, 2013

FILED WITH LRC: December 30, 2013 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of 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 February 14, 2014, 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 February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the reimbursement provisions and requirements regarding Medicaid Program behavioral health services provided by certain licensed behavioral health professionals who are independently enrolled in the Medicaid Program as Medicaid providers, or behavioral health service practitioners working under for or under supervision of the independent behavioral health service providers, to Medicaid recipients who are not enrolled with a managed care organization. This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations – 907 KAR 15:010

(Provisions and requirements regarding behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for KAR Chapter 15). Currently, the Department for Medicaid Services does not enroll licensed psychologists, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, or licensed psychological practitioners as independent Medicaid providers. Rather these providers have to work for or under contract with - for example - a community mental health center, a physician's office, a federally-qualified health center, or a rural health clinic among other entities and the entity bills (and is reimbursed by) the Medicaid Program for the services provided. This administrative regulation also establishes practitioners who may provide behavioral health services under supervision of one (1) of the aforementioned independent providers and in which case the Medicaid Program will reimburse the independent provider (billing provider) for the services.

(b) The necessity of this administrative regulation: This administrative regulation is being promulgated in conjunction with two (2) administrative regulations – 907 KAR 15:010 (Provisions and requirements regarding behavioral health services provided by independent providers) and 907 KAR 15:005 (Definitions for KAR Chapter 15) - to comply with a federal mandate and to enhance recipient access to services. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment" for all recipients. Currently, DMS covers substance use treatment for pregnant women and children. Additionally, this administrative regulation is necessary to enhance Medicaid recipient access to behavioral health services by expanding the providers and practitioners authorized to provide the services as independent providers or as practitioners working under the supervision of an independent provider. The Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange.

(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 complying with a federal mandate and by enhancing and ensuring Medicaid recipients' access to behavioral health 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 authorizing statutes by complying with a federal mandate and by enhancing and ensuring Medicaid recipients' access to behavioral health 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: Licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, and licensed psychological practitioners who wish to enroll in the Medicaid Program as independent providers will be affected by this administrative regulation. Licensed psychological associates, certified social workers (master's level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide behavioral health services while working for one (1) of the aforementioned independent providers will also be affected by this administrative regulation. Medicaid recipients who qualify for behavioral health services will be affected by this 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. Individuals listed in question (3) who wish to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the individual wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Individuals who wish to provide behavioral health services to Medicaid recipients per this administrative regulation could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An individual who enrolls with the Medicaid Program to provide behavioral health services will benefit by being reimbursed for services provided to Medicaid recipients. Behavioral health service practitioners who can work for an independent behavioral health service provider will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of behavioral health services will benefit from an expanded base of providers from which to receive these services.

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

(a) Initially: DMS is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)

(b) On a continuing basis: The response to question (a) also applies here.

(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 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 to implement this administrative regulation.

(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 policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), and 42 U.S.C. 1396a(a)(30)(A).

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. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization's provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky's Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "...provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

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 the amendment to 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 is unable to accurately estimate the costs of expanding the behavioral health provider base due to the variables involved as DMS cannot estimate how many individual behavioral health professionals will enroll in the Medicaid Program, nor the utilization of substance use disorder services beyond the current utilization (pregnant women and children), nor the utilization of enhanced behavioral health services, nor the utilization of these services in the independent provider realm versus the realm of currently authorized providers (community mental health centers, federally-qualified health centers, rural health clinics, primary care centers, and physician offices.)

(d) How much will it cost to administer this program for subsequent years? The response to question (a) also applies here.

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:

ADMINISTRATIVE REGULATION REVIEW SUBCOMMITTEE
Minutes of January 13, 2014

Call to Order and Roll Call

The January 2014 meeting of the Administrative Regulation Review Subcommittee was held on Monday, January 13, 2014, at 1:00 p.m., in Room 154 of the Capitol Annex. Representative Johnny Bell, Co-chair, called the meeting to order, the roll call was taken. The minutes of the December 2013 meeting were approved.

Present were:

Members: Senators Sara Beth Gregory, Ernie Harris; and Representatives Johnny Bell, Robert Damron, Jimmie Lee, and Tommy Turner.

LRC Staff: Donna Little, Emily Caudill, Sarah Amburgey, Carrie Klaber, Emily Harkenrider, Karen Howard, Laura Napier, and Betsy Cupp.

Guests: Becky Gilpatrick, Kentucky Higher Education Assistance Authority; Alicia Sneed, Education Professional Standards Board; Jennifer Jones, Chris Tapia, Bill Thielen, Brian Thomas, Kentucky Retirement Systems; Nathan Goldman, Paula Schenk, Board of Nursing; Margaret Everson, Karen Waldrop, David Wicker, Department of Fish and Wildlife Resources; Kristen Branscum, James Comer, Clint Quarles, Dr. Robert Stout, Adam Watson, Department of Agriculture; Kevin Brown, Kay Kennedy, Amy Peabody, Karen Kidwell, Department of Education; Elizabeth Caywood, Virginia Carrington, Martha Hockensmith, Chandra Jones, Wendy Morris, Cabinet for Health and Family Services, Jeff Harper, Kentucky Farm Bureau, and Dave Maples, Kentucky Cattleman's Association.

The Administrative Regulation Review Subcommittee met on Monday, January 13, 2014, and submits this report:

Administrative Regulations Reviewed by the Subcommittee:

**KENTUCKY HIGHER EDUCATION ASSISTANCE AUTHORITY:
Division of Student and Administrative Services:
Commonwealth Merit Scholarship Program**

11 KAR 15:090. Kentucky Educational Excellence Scholarship (KEES) Program. Becky Gilpatrick, director of student aid services, represented the division.

**EDUCATIONAL PROFESSIONAL STANDARDS BOARD:
Educator Preparation**

16 KAR 5:020. Standards for admission to educator preparation. Alicia Sneed, director of legal services, represented the board.

A motion was made and seconded to approve the following amendments: to amend Sections 1 and 2 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Assessment

16 KAR 6:010. Examination prerequisites for teacher certification.

A motion was made and seconded to approve the following amendments: to amend Sections 1, 2, and 4 through 7 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

FINANCE AND ADMINISTRATION CABINET: Kentucky Retirement Systems: General Rules

105 KAR 1:140 & E. Employer's administrative duties. Bill Thielan, executive director, and Brian Thomas, general counsel, represented the systems.

Mr. Thielan stated that the systems sent a letter to Subcommittee members explaining this administrative regulation and, in that letter, presented theoretical fiscal impact information.

In response to a question by Co-Chair Harris, Mr. Thielan stated that changing the spiking requirements in this administrative regulation would first require amendment to the authorizing statute, which strictly defined spiking as it related to overtime.

In response to questions by Co-Chair Bell, Mr. Thielan stated that the systems was not currently soliciting legislators to amend the authorizing statute for this administrative regulation because the current statute assisted budget shortfalls. The systems would implement whatever legislation the General Assembly enacted. An emergency situation that required significant overtime would require the systems to treat the compensation as spiking. The theoretical fiscal impact information provided with the systems' letter to Subcommittee members included an example of an emergency situation that resulted in spiking.

A motion was made and seconded at the December meeting of the Subcommittee to approve the following amendments: (1) to delete Section 1(9)(b,) which prohibited an employer in the County Employees Retirement System from classifying an employee as temporary or probationary more than once; and (2) to add Section 8(13), which stated that an employer required to pay the additional actuarial cost pursuant to KRS 61.598 shall be treated as a participating employer in the system to which the employer is required to pay the additional actuarial cost solely for purposes of making the required payment. Without objection, and with agreement of the agency, the amendments were approved.

GENERAL GOVERNMENT CABINET: Board of Nursing: Board

201 KAR 20:056. Advanced practice registered nurse licensure, program requirements, recognition of a national certifying organization. Nathan Goldman, general counsel, and Paula Schenk, executive director, represented the board.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs and Section 1 to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (3) to amend Sections 1, 2, 3, 5, 6, 9, 10, and 11 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:061. Approval of Doctor of Nursing Practice (DNP) degree programs.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (3) to amend Section 2 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:062. Standards for advanced practice registered nurse (APRN) programs of nursing.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs to correct statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; (3) to amend Sections 1 through 10 to comply with the drafting requirements of KRS Chapter 13A; and (4) to amend Section 4 to change references from "nursing unit administrator" to "designated chief nursing academic officer." Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:240. Fees for applications and for services.

In response to a question by Senator Kerr, Mr. Goldman stated that all nursing programs had finished the application process for APRN programs; therefore, the application fee was deleted because it was obsolete.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs to correct statutory citations; and (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Section 1 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:260. Organization and administration standards for prelicensure programs of nursing.

In response to a question by Co-Chair Harris, Mr. Goldman stated that the deletion in this administrative regulation and in 201 KAR 20:310 of the twenty-five (25) percent time minimum was appropriate because this requirement was no longer necessary. Sometimes these nursing administrators became overwhelmed, and time minimums were generally used to ensure adequate time for certain required duties. Other board administrative regulations included time minimum requirements to provide that protection to nursing administrators.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and STATUTORY AUTHORITY paragraphs to add statutory citations; and (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 2 and 3 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:270. Programs of nursing site visits.

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 and 2 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:280. Standards for initial approval of prelicensure registered nurse and practical nurse programs.

A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph to add a statutory citation; and (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 1 through 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.

201 KAR 20:290. Standards for prelicensure registered nurse and practical nurse secondary sites.

A motion was made and seconded to approve the following amendments: to amend Sections 2 through 6 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:310. Faculty for prelicensure registered nurse and practical nurse programs.

A motion was made and seconded to approve the following amendments: to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 2, 3, and 6 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:320. Standards for curriculum of prelicensure nursing programs.

A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph to add a statutory citation; and (2) to amend Sections 1

and 2 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 20:390. Nursing Incentive Scholarship Fund.

A motion was made and seconded to approve the following amendments: (1) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to clearly state the necessity for and function served by this administrative regulation, as required by KRS 13A.220; and (2) to amend Sections 1, 2, 4, 7, 8, 9, 11, and 12 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

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

301 KAR 2:221 & E. Waterfowl seasons and limits. Margaret Everson, assistant attorney general, and Karen Waldrop, wildlife division director, represented the department.

A motion was made and seconded to approve the following amendments: (1) to amend Sections 1, 3, and 6 to comply with the drafting and formatting requirements of KRS Chapter 13A; and (2) to amend Section 8 and add Section 9 to incorporate forms by reference. Without objection, and with agreement of the agency, the amendments were approved.

301 KAR 2:222 & E. Waterfowl hunting requirements on public lands.

A motion was made and seconded to approve the following amendments: (1) to amend Sections 1, 3, and 4 to comply with the drafting requirements of KRS Chapter 13A; and (2) to amend Sections 4 and 5 and add Section 8 to incorporate forms by reference. Without objection, and with agreement of the agency, the amendments were approved.

GENERAL GOVERNMENT CABINET: Department of Agriculture: Office of Consumer and Environmental Protection: Division of Environmental Services: Livestock

302 KAR 21:001. Definitions for 302 KAR Chapter 21. James Comer, commissioner; Jeff Harper, director of public affairs, Kentucky Farm Bureau; Dave Maples, Kentucky Cattlemen's Association; and Dr. Robert Stout, state veterinarian, represented the division. Representative Tom McKee appeared in support of these administrative regulations.

Representative McKee stated that these administrative regulations were good for the livestock industry.

A motion was made and seconded at the December meeting of the Subcommittee to approve the following amendments: to amend the definition for "soring" to clarify that a chemical agent shall be applied intentionally to create an equine abrasion. Without objection, and with agreement of the agency, the amendments were approved.

302 KAR 21:020. General livestock and poultry provisions.

302 KAR 21:030. Beef cattle, bison, and veal specific provisions.

302 KAR 21:040. Dairy cattle specific provisions.

302 KAR 21:050. Equine specific provisions.

302 KAR 21:060. Swine specific provisions.

A motion was made and seconded at the December meeting of the Subcommittee to approve the following amendment: to add Section 3 to incorporate by reference the Pork Quality Assurance Guidelines. Without objection, and with agreement of the agency, the amendment was approved.

302 KAR 21:070. Ovine, caprine, camelid and cervid specific provisions.

302 KAR 21:080. Poultry specific provisions.

**Office of Agricultural Marketing and Product Promotion:
Organic Agricultural Product Certification**

302 KAR 40:010. Certification of organic production, processing, or handling operations. Kristen Branscum, executive director for markets; James Comer, commissioner; Clint Quarles, staff attorney, and Adam Watson, value-added plant production, represented the department.

In response to a question by Co-Chair Harris, Mr. Comer stated that there had been an increased demand for organics, but Kentucky had been at risk because the program was inadequate and did not comply with new federal mandates such as soil testing requirements. This administrative regulation would improve Kentucky's program.

A motion was made and seconded to approve the following amendments: (1) to amend Section 1 to clarify that a producer, processor, or handler shall comply with the department's Quality Manual and application requirements in addition to the National Organic Program standards; (2) to amend Section 2 to: (a) clarify application and inspection procedures; (b) specify that fees shall be calculated in accordance with the Fee Schedule; (c) establish registration procedures for small operations; and (d) establish procedures for withdrawing a certification application or surrendering a certification; (3) to amend Section 3 to establish registration procedures for nonprofit, educational, or charitable organizations that have less than \$5,000 gross sales of organic products; (4) to amend Section 4 to clarify membership requirements for the Organic Agricultural Advisory Committee; (5) to amend Section 5 to clarify procedures for requesting export documentation; and (6) to amend Section 6 to: (a) incorporate by reference additional required forms; and (b) make technical corrections to existing forms. Without objection, and with agreement of the agency, the amendments were approved.

**EDUCATION AND WORKFORCE DEVELOPMENT CABINET:
Kentucky Board of Education: Department of Education:
School Terms, Attendance and Operation**

702 KAR 7:125. Pupil attendance. Kay Kennedy, director of district support, and Amy Peabody, assistant general counsel, represented the department.

In response to questions by Co-Chair Bell, Ms. Kennedy stated that this administrative regulation provided guidance for maintaining attendance records for purposes of the SEEK funding calculation. The actual attendance data, not estimates, were used on a daily and even an hourly basis, except for a provision for a substitution for inclement weather days.

A motion was made and seconded to approve the following amendments: (1) to amend Sections 9 and 10 for clarity; and (2) to amend Section 12 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Office of Instruction

704 KAR 3:305. Minimum requirements for high school graduation. Kevin Brown, general counsel, and Karen Kidwell, division director, represented the department.

**CABINET FOR HEALTH AND FAMILY SERVICES: 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. Elizabeth Caywood, policy analyst; Virginia Carrington, assistant director; and Wendy Morris, deputy commissioner, represented the division.

A motion was made and seconded to approve the following amendments: (1) to amend Sections 1, 2, 3, 7, and 8 to update citations; (2) to amend Section 6 to clarify what shall be considered a major area of living; (3) to amend Section 9 to correct the starting date for the 2013 standard of need for individuals with serious mental illness; and (4) to amend Section 17 to make minor technical corrections to two (2) forms incorporated by reference. Without objection, and with agreement of the agency, the amendments were approved.

Food Stamp Program

921 KAR 3:090 & E. Simplified assistance for the elderly program or "SAFE".

In response to questions by Representative Lee, Ms. Caywood stated that benefit amounts were being lowered because funding for federal portions of the program had been terminated. The actual benefit reductions were established in the material incorporated by reference. A one (1) person household would experience an eleven (11) dollar reduction, while a two (2) person household would experience a twenty (20) dollar reduction. Congress was still debating this issue, so it was not possible to determine if funding would be reinstituted or if further reductions would take place. Approximately 13,500 participants were enrolled, all of whom would be impacted. The vast majority of households were one (1) person households.

A motion was made and seconded to approve the following amendments: to amend Sections 3 and 6 for clarity. Without objection, and with agreement of the agency, the amendments were approved.

Other Business: Co-Chair Bell welcomed Senator Alice Forgy Kerr back to the Subcommittee. She replaced Senator Joe Bowen, who resigned from the Subcommittee.

The following administrative regulations were deferred to the February 10, 2014, meeting of the Subcommittee:

**JUSTICE AND PUBLIC SAFETY CABINET: Department of
Juvenile Justice: Child Welfare**

505 KAR 1:130. Department of Juvenile Justice Policies and Procedures: juvenile services in community.

**EDUCATION AND WORKFORCE DEVELOPMENT CABINET:
Kentucky Board of Education: Department of Education:
Office of Learning Support Services**

704 KAR 7:151. Repeal of 704 KAR 7:150.

**CABINET FOR HEALTH AND FAMILY SERVICES: Department
for Medicaid Services: Division of Community Alternatives:
Certified Provider Requirements**

907 KAR 7:005. Certified waiver provider requirements.

The Subcommittee adjourned at 1:50 p.m. until February 10, 2014 at 1:30 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.

HOUSE STANDING COMMITTEE ON HEALTH AND WELFARE
Meeting of January 9, 2014

The following administrative regulations were available for consideration and placed on the agenda of the House Standing Committee on Health and Welfare for its meeting of January 9, 2014, having been referred to the Committee on January 2, 2014, pursuant to KRS 13A.290(6):

201 KAR 9:081
900 KAR 5:020 & E
902 KAR 20:058

Committee activity in regard to review of the above-referenced administrative regulations is reflected in the minutes of the January 9, 2014 meeting, which are hereby incorporated by reference.

SENATE STANDING COMMITTEE ON HEALTH AND WELFARE
Meeting of January 15, 2014

The following administrative regulations were available for consideration and placed on the agenda of the Senate Standing Committee on Health and Welfare for its meeting of January 15, 2014, having been referred to the Committee on January 2, 2014, pursuant to KRS 13A.290(6):

201 KAR 9:081
900 KAR 5:020 & E
902 KAR 20:058

Committee activity in regard to review of the above-referenced administrative regulations is reflected in the minutes of the January 15, 2014 meeting, which are hereby incorporated by

SENATE STANDING COMMITTEE ON EDUCATION
Meeting of January 23, 2014

The following administrative regulations were available for consideration and placed on the agenda of the Senate Standing Education Committee on Education for its meeting of January 23, 2014, having been referred to the Committee on January 2, 2014, pursuant to KRS 13A.290(6):

11 KAR 15:020
13 KAR 3:050
702 KAR 6:101

The following administrative regulations were found to be deficient pursuant to KRS 13A.290(7) and 13A.030(2):

None

The Committee rationale for each finding of deficiency is attached to and made a part of this memorandum.

The following administrative regulations were approved as amended at the Committee meeting pursuant to KRS 13A.320:

None

The wording of the amendment of each such administrative regulation is attached to and made a part of this memorandum.

The following administrative regulations were deferred pursuant to KRS 13A.300:

None

Committee activity in regard to review of the above-referenced administrative regulations is reflected in the minutes of the January 23, 2014 meeting, which are hereby incorporated by reference. Additional committee findings, recommendations, or comments, if any, are attached hereto.

HOUSE STANDING COMMITTEE ON EDUCATION
Meeting of January 28, 2014

The following administrative regulations were available for consideration and placed on the agenda of the House Standing Education Committee on Education for its meeting of January 28, 2014, having been referred to the Committee on January 2, 2014, pursuant to KRS 13A.290(6):

11 KAR 15:020
13 KAR 3:050
702 KAR 6:101

The following administrative regulations were found to be deficient pursuant to KRS 13A.290(7) and 13A.030(2):

None

The Committee rationale for each finding of deficiency is attached to and made a part of this memorandum.

The following administrative regulations were approved as amended at the Committee meeting pursuant to KRS 13A.320:

None

The wording of the amendment of each such administrative regulation is attached to and made a part of this memorandum.

The following administrative regulations were deferred pursuant to KRS 13A.300:

None

Committee activity in regard to review of the above-referenced administrative regulations is reflected in the minutes of the January 23, 2014 meeting, which are hereby incorporated by reference. Additional committee findings, recommendations, or comments, if any, are attached hereto.

CUMULATIVE SUPPLEMENT

Locator Index - Effective Dates

H - 2

The Locator Index lists all administrative regulations published in VOLUME 40 of the *Administrative Register of Kentucky* from July 2013 through June 2014. 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 39 are those administrative regulations that were originally published in VOLUME 39 (last year's) issues of the *Administrative Register of Kentucky* but had not yet gone into effect when the *2013 Kentucky Administrative Regulations Service* was published.

KRS Index

H - 13

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 40 of the *Administrative Register of Kentucky*.

Technical Amendment Index

H - 25

The Technical Amendment Index is a list of administrative regulations which have had technical, nonsubstantive amendments entered since being published in the *2013 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

H - 26

The Subject Index is a general index of administrative regulations published in VOLUME 40 of the *Administrative Register of Kentucky*, and is mainly broken down by agency.

LOCATOR INDEX - EFFECTIVE DATES

Regulation Number	39 Ky.R. Page No.	Effective Date	Regulation Number	39 Ky.R. Page No.	Effective Date
VOLUME 39					
The administrative regulations listed under VOLUME 39 are those administrative regulations that were originally published in Volume 38 (last year's) issues of the <i>Administrative Register of Kentucky</i> but had not yet gone into effect when the <i>2013 Kentucky Administrative Regulations Service</i> was published.					
SYMBOL KEY:			Amended	2362	(See 40 Ky.R.)
* Statement of Consideration not filed by deadline			101 KAR 2:102		
** Withdrawn, not in effect within 1 year of publication			Amended	2365	(See 40 Ky.R.)
*** Withdrawn before being printed in Register			101 KAR 3:015		
**** Emergency expired after 180 days			Amended	2370	(See 40 Ky.R.)
(r) Repealer regulation: KRS 13A.310-on the effective date of			101 KAR 3:050		
an administrative regulation that repeals another, the			Amended	2375	(See 40 Ky.R.)
regulations compiler shall delete the repealed administrative			201 KAR 2:020		
regulation and the repealing administrative regulation.			Amended	2377	9-6-13
-----			201 KAR 2:030		
EMERGENCY ADMINISTRATIVE REGULATIONS:			Amended	2378	9-6-13
(Note: Emergency regulations expire 180 days from the date filed;			201 KAR 2:074		
or 180 days from the date filed plus number of days of requested			Amended	1753	
extension, or upon replacement or repeal, whichever occurs first.)			Amended	2175	
103 KAR 3:040	1862	1-15-13	As Amended	2312	6-19-13
301 KAR 2:195E	1574	12-28-12	201 KAR 18:040		
900 KAR 10:010E	2296	5-13-13	Amended	2380	9-6-13
Replaced	1075	12-10-13	201 KAR 18:072		
907 KAR 1:055E	1987	3-1-13	Amended	2382	9-6-13
Replaced	299	9-6-13	201 KAR 18:142		
907 KAR 1:056E(r)	1993	3-1-13	Amended	2383	(See 40 Ky.R.)
Expires		8-28-13	201 KAR 20:057		
907 KAR 1:711E	1587	12-21-12	Amended	2191	(See 40 Ky.R.)
Expired		6-19-13	201 KAR 20:059		
907 KAR 3:015E	2112	4-3-13	Amended	2046	
907 KAR 3:225E	2301	5-8-13	As Amended	2314	6-19-13
Replaced	844	11-1-13	201 KAR 20:070		
907 KAR 3:230E	2306	5-8-13	Amended	2194	(See 40 Ky.R.)
Replaced	848	11-1-13	201 KAR 20:085		
907 KAR 17:005E	1589	12-21-12	Amended	2196	7-17-2013
Replaced	2322	6-5-13	201 KAR 20:110		
907 KAR 17:010E	1610	12-21-12	Amended	2197	7-17-2013
Replaced	2343	6-5-13	201 KAR 20:400		
907 KAR 17:015E	1620	12-21-12	Amended	2047	(See 40 Ky.R.)
907 KAR 17:020E	1625	12-21-12	201 KAR 20:500		
Replaced	2353	6-5-13	Amended	2049	
907 KAR 17:025E	1630	12-21-12	As Amended	2315	6-19-13
Replaced	2356	6-5-13	201 KAR 31:010		
907 KAR 17:030E	1635	12-21-12	Amended	2386	(See 40 Ky.R.)
Replaced	1846	6-5-13	201 KAR 31:020		
921 KAR 2:015E	1639	12-21-12	Amended	2387	10-4-13
Replaced	1813	6-19-13	201 KAR 31:040		
921 KAR 3:090E	2115	3-28-13	Amended	2388	(See 40 Ky.R.)
922 KAR 1:130E	2117	3-28-13	201 KAR 31:050		
Replaced	550	9-18-13	Amended	2390	(See 40 Ky.R.)
922 KAR 1:140E	2122	3-28-13	201 KAR 31:060		
Replaced	554	9-18-13	Amended	2391	(See 40 Ky.R.)
922 KAR 1:320E	2126	3-28-13	201 KAR 31:080		
Replaced	556	9-18-13	Amended	2393	(See 40 Ky.R.)
922 KAR 1:400E	2130	3-28-13	201 KAR 31:090		
Replaced	559	9-18-13	Amended	2395	(See 40 Ky.R.)
922 KAR 2:090E	2134	3-27-13	202 KAR 7:330		
Replaced	305	9-18-13	Amended	2050	(See 40 Ky.R.)
922 KAR 2:160E	2140	3-27-13	202 KAR 7:520		
Replaced	571	9-18-13	Amended	2056	(See 40 Ky.R.)
ORDINARY ADMINISTRATIVE REGULATIONS:			2092		(See 40 Ky.R.)
17 KAR 3:010			301 KAR 1:015		
Amended	1897		Amended	2199	8-2-13
As Amended	2310	7-5-13	301 KAR 1:122		
17 KAR 3:040	1963	7-5-13	Amended	2201	(See 40 Ky.R.)
101 KAR 2:076			301 KAR 2:049		
Amended	2361	(See 40 Ky.R.)	Amended	2061	6-6-13
101 KAR 2:095			301 KAR 2:122		
			Amended	2064	6-6-13

LOCATOR INDEX - EFFECTIVE DATES

Regulation Number	39 Ky.R. Page No.	Effective Date	Regulation Number	39 Ky.R. Page No.	Effective Date
301 KAR 2:251			As Amended	1413	
Amended	2397	(See 40 Ky.R.)	As Amended	2033	
401 KAR 10:030			906 KAR 1:160		
Amended	584		Amended	335	
Withdrawn	‡	11-19-13	As Amended	632	
401 KAR 5:320	2094	(See 40 Ky.R.)	Amended	1221	
501 KAR 6:070			907 KAR 1:055		
Amended	1949		Amended	2084	(See 40 Ky.R.)
As Amended	2316	7-5-13	907 KAR 1:070		
503 KAR 1:170			Repealed	2448	9-6-13
Amended	2066		907 KAR 1:071(r)	2448	9-6-13
As Amended	2317	7-5-13	907 KAR 1:072		
505 KAR 1:160			Repealed	2448	9-6-13
Amended	1952		907 KAR 1:090		
As Amended	2173		Repealed	2448	9-6-13
601 KAR 9:135			907 KAR 1:092		
Amended	1953		Repealed	2448	9-6-13
702 KAR 3:130			907 KAR 1:320		
Amended	1321		Repealed	2448	9-6-13
Amended	1891		907 KAR 10:017		
As Amended	2173		Repealed	2448	
702 KAR 4:160			907 KAR 10:372		
Amended	2073	(See 40 Ky.R.)	Repealed	2448	
703 KAR 5:121(r)	2098		907 KAR 10:376		
Withdrawn		6-11-13	Repealed	2448	
703 KAR 5:250	2099		907 KAR 1:563		
Withdrawn		6-11-13	Amended	2434	(See 40 Ky.R.)
787 KAR 1:010			907 KAR 1:595		
Amended	2400	9-6-13	Amended	2438	
787 KAR 1:290			907 KAR 3:225	2449	(See 40 Ky.R.)
Amended	2401	9-6-13	907 KAR 3:230	2454	(See 40 Ky.R.)
804 KAR 9:040			907 KAR 3:015	2284	(See 40 Ky.R.)
Amended	1958		907 KAR 17:005		
Amended	2178		Amended	1792	
Withdrawn		7-10-13	As Amended	2322	9-19-13
804 KAR 9:050			907 KAR 17:010	1822	
Amended	1961	(See 40 Ky.R.)	Amended	2181	
815 KAR 4:027	1970		As Amended	2343	6-27-13
As Amended	2174		907 KAR 17:015	1831	
815 KAR 7:120			As Amended	2350	6-27-13
Amended	1506	(See 40 Ky.R.)	907 KAR 17:020	1836	
815 KAR 20:020			As Amended	2353	6-27-13
Amended	2203	8-2-13	907 KAR 17:025	1841	
815 KAR 20:034			As Amended	2356	6-27-13
Amended	2208	(See 40 Ky.R.)	907 KAR 17:030	1846	6-27-13
815 KAR 20:120			921 KAR 2:015		
Amended	2210	8-2-13	Amended	1813	6-19-13
900 KAR 5:020			921 KAR 3:090		
Amended	1322		Amended	2218	(See 40 Ky.R.)
Amended	1895		922 KAR 1:130		
As Amended	2174		Amended	2220	(See 40 Ky.R.)
900 KAR 10:010	2443	(See 40 Ky.R.)	922 KAR 1:140		
902 KAR 30:001			Amended	2225	(See 40 Ky.R.)
Amended	2403	(See 40 Ky.R.)	922 KAR 1:320		
902 KAR 30:120			Amended	2228	(See 40 Ky.R.)
Amended	2410	(See 40 Ky.R.)	922 KAR 1:400		
902 KAR 30:130			Amended	2233	(See 40 Ky.R.)
Amended	2413	(See 40 Ky.R.)	922 KAR 2:020		
902 KAR 30:150			Amended	2236	(See 40 Ky.R.)
Amended	2419	10-16-13	922 KAR 2:090		
902 KAR 30:160			Amended	2241	(See 40 Ky.R.)
Amended	2422	10-16-13	922 KAR 2:100		
902 KAR 30:180		(See 40 Ky.R.)	Amended	2247	(See 40 Ky.R.)
Amended	2425	10-16-13	922 KAR 2:110		
902 KAR 30:200			Amended	2256	(See 40 Ky.R.)
Amended	2428	10-16-13	922 KAR 2:120		
902 KAR 55:110			Amended	2261	(See 40 Ky.R.)
Amended	629		922 KAR 2:160		
Amended	1218		Amended	2269	(See 40 Ky.R.)

LOCATOR INDEX - EFFECTIVE DATES

Regulation Number	39 Ky.R. Page No.	Effective Date	Regulation Number	39 Ky.R. Page No.	Effective Date
922 KAR 2:180 Amended	2278		*** 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		
SYMBOL KEY:					
* Statement of Consideration not filed by deadline					
** Withdrawn, not in effect within 1 year of publication					

VOLUME 40

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.)

30 KAR 5:010E	219	6-28-2013	900 KAR 10:020E	8	6-07-2013
Replaced	775	11-1-13	Replaced	1080	12-10-2013
30 KAR 5:020E	220	6-28-2013	900 KAR 10:030E	762	8-22-2013
Replaced	775	11-1-13	Replaced	1283	1-3-14
30 KAR 5:030E	223	6-28-2013	900 KAR 10:050E	255	7-10-2013
Replaced	777	11-1-13	Replaced	1083	12-10-2013
30 KAR 5:040E	225	6-28-2013	900 KAR 10:100E	1568	12-17-13
Replaced	777	11-1-13	907 KAR 1:019E	1573	12-30-13
30 KAR 5:050E	228	6-28-2013	907 KAR 1:030E	1581	12-26-13
Replaced	780	11-1-13	907 KAR 1:038E	1585	12-26-13
30 KAR 5:060E	230	6-28-2013	907 KAR 1:039E	1591	12-26-13
Replaced	781	11-1-13	907 KAR 1:044E	1595	12-30-13
31 KAR 4:070E	755	9-4-2013	907 KAR 1:045E	1600	12-30-13
Replaced	882	1-3-14	907 KAR 1:054E	1603	12-30-13
101 KAR 2:210E	756	9-9-2013	907 KAR 1:082E	1617	12-30-13
Replaced	884	1-3-14	907 KAR 1:604E	1631	12-26-13
103 KAR 3:010E	1529	12-27-13	907 KAR 1:631E	1638	12-26-13
103 KAR 3:020E	1534	12-27-13	907 KAR 1:632E	1642	12-26-13
103 KAR 3:030E	1540	12-27-13	907 KAR 1:913Er	1646	12-26-13
103 KAR 3:040E	1550	12-27-13	907 KAR 3:005E	1648	12-26-13
105 KAR 1:140E	233	7-01-2013	907 KAR 8:005E	1655	12-26-13
109 KAR 16:010E	1561	12-18-13	907 KAR 8:010E	1657	12-26-13
201 KAR 22:055E	4	5-15-2013	907 KAR 8:015E	1660	12-26-13
Withdrawn		9-17-2013	907 KAR 8:020E	1662	12-26-13
201 KAR 30:315E	935	10-10-2013	907 KAR 8:025E	1665	12-26-13
Replaced	1396	2-3-14	907 KAR 8:030E	1668	12-26-13
301 KAR 2:221E	1232	10-21-2013	907 KAR 8:035E	1671	12-26-13
301 KAR 2:222E	1234	10-21-2013	907 KAR 10:014E	1673	12-26-13
301 KAR 2:225E	524	8-14-2013	907 KAR 13:005E	1677	12-26-13
Replaced	1045	11-7-13	907 KAR 13:010E	1680	12-26-13
405 KAR 10:001E	236	7-03-2013	907 KAR 13:015E	1683	12-26-13
405 KAR 10:070E	240	7-03-2013	907 KAR 15:005E	1686	12-30-13
Replaced	1065	11-7-13	907 KAR 15:010E	1688	12-30-13
405 KAR 10:080E	243	7-03-2013	907 KAR 15:015E	1691	12-30-13
Replaced	1066	11-7-13	907 KAR 20:001E	938	9-30-2013
405 KAR 10:090E	245	7-03-2013	907 KAR 20:005E	944	9-30-2013
Replaced	1067	11-7-13	907 KAR 20:010E	952	9-30-2013
405 KAR 10:201E	246	7-03-2013	907 KAR 20:015E	956	9-30-2013
Repealer		11-7-2013	907 KAR 20:020E	959	9-30-2013
501 KAR 6:020E	759	8-20-2013	907 KAR 20:025E	964	9-30-2013
505 KAR 1:170E	936	10-14-2013	907 KAR 20:030E	969	9-30-2013
Replaced	1398	2-3-14	907 KAR 20:035E	974	9-30-2013
804 KAR 4:390E	5	6-14-2013	907 KAR 20:040E	979	9-30-2013
804 KAR 4:400E	247	6-25-2013	907 KAR 20:045E	983	9-30-2013
Replaced	811	11-1-13	907 KAR 20:050E	986	9-30-2013
804 KAR 4:410E	249	6-25-2013	907 KAR 20:060E	990	9-30-2013
Replaced	811	11-1-13	907 KAR 20:075E	993	9-30-2013
804 KAR 4:430E	7	6-14-2013	907 KAR 20:100E	997	9-30-2013
815 KAR 4:030E	250	6-25-2013	921 KAR 2:015E	1238	11-14-2013
Replaced	824	10-23-13	921 KAR 3:090E	1245	10-30-2013
815 KAR 4:040E	253	6-25-2013	ORDINARY ADMINISTRATIVE REGULATIONS:		
Replaced	825	10-23-13	11 KAR 3:100		
900 KAR 5:020E	761	8-30-2013	Amended	58	9-9-13
Replaced	894	1-15-14	11 KAR 4:080		
900 KAR 7:030E	1564	12-17-13	Amended	1812	
			11 KAR 5:001		
			Amended	72	
			As Amended	527	9-9-13
			11 KAR 5:140		

LOCATOR INDEX - EFFECTIVE DATES

Regulation Number	39 Ky.R. Page No.	Effective Date	Regulation Number	39 Ky.R. Page No.	Effective Date
Amended	75	9-9-13	As Amended	775	11-1-13
11 KAR 5:145			30 KAR 5:020		
Amended	76	9-9-13	Amended	343	
11 KAR 8:030			As Amended	775	11-1-13
Amended	78		30 KAR 5:030		
As Amended	528	9-9-13	Amended	346	
11 KAR 15:020			As Amended	777	11-1-13
Amended	1129	1-28-14	30 KAR 5:040		
11 KAR 15:040			Amended	348	
Amended	82		As Amended	777	11-1-13
As Amended	531	9-9-13	30 KAR 5:050		
11 KAR 15:090			Amended	351	
Amended	84	9-9-13	As Amended	780	11-1-13
Amended	1313		30 KAR 5:060		
11 KAR 16:001			Amended	353	
Amended	88	9-9-13	As Amended	781	11-1-13
11 KAR 16:010			31 KAR 4:070		
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605 KAR 1:060			Amended	146	10-4-13
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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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