ADMINISTRATIVE REGISTER OF KENTUCKY

LEGISLATIVE RESEARCH COMMISSION
Frankfort, Kentucky

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THURSDAY, MAY 1, 2014

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

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MEETING NOTICE: ARRS

The **Administrative Regulation Review Subcommittee** is **tentatively** scheduled to meet May 13, 2014 at 1:00 p.m. in room 149 Capitol Annex. See **tentative agenda** on pages **2397-2399** of this Administrative Register.

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

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ADMINISTRATIVE REGULATION REVIEW SUBCOMMITTEE
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FINANCE AND ADMINISTRATION CABINET
Kentucky Teachers' Retirement System

General Rules

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102 KAR 1:320. Qualified domestic relations orders.

OFFICE OF THE GOVERNOR
Department for Local Government

County Budget

109 KAR 15:020. County Budget Preparation and State Local Finance Officer Policy Manual. (Deferred from April)

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Board

201 KAR 3:025. Reciprocity requirements.
201 KAR 3:090. Administrative fees for applications and services.

Board of Dentistry

Board

201 KAR 8:016. Registration of dental laboratories.
201 KAR 8:532. Licensure of dentists.
201 KAR 8:550. Anesthesia and sedation.
201 KAR 8:562. Licensure of dental hygienists.
201 KAR 8:571. Registration of dental assistants.

Board of Barbering

Board

201 KAR 14:085. Sanitation requirements. (Deferred from March)
201 KAR 14:090. School curriculum. (Deferred from April)
201 KAR 14:115. Examinations; school and board. (Deferred from March)

Board of Nursing

Board

201 KAR 20:360. Evaluation of prelicensure registered nurse and practical nurse programs.

Board of Physical Therapy

Board

201 KAR 22:160. Telehealth and telephysical therapy. (Deferred from April)

Board of Licensure for Professional Art Therapists

Board

201 KAR 34:060. Qualifying experience under supervision.

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Department of Fish and Wildlife Resources

Game

301 KAR 2:132. Elk depredation permits, landowner cooperator permits, and quota hunts.

JUSTICE AND PUBLIC SAFETY CABINET
Department of State Police
Driver Testing Branch

Breath Analysis Operators

500 KAR 8:030. Administration of breath alcohol tests and chemical analysis tests. (Deferred from April)

Department of Corrections

Office of the Secretary

501 KAR 6:020. Corrections policies and procedures.

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Department of Highways
Division of Professional Services

Professional Engineering and Related Services

600 KAR 6:040. Prequalification of firms for engineering or engineering-related services.

Department of Vehicle Regulation
Division of Motor Carriers

Motor Carriers

601 KAR 1:230. Education and safety training for motor carrier operations.

LABOR CABINET
Kentucky Occupational Safety and Health Review Commission

Commission

803 KAR 50:010. Hearings; Procedure, Disposition. (Deferred from February)

PUBLIC PROTECTION CABINET
Department of Alcoholic Beverage Control

Advertising Distilled Spirits and Wine
804 KAR 1:051. Repeal of 804 KAR 1:050.
Quotas
804 KAR 9:050. Quota retail drink licenses.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services

Medicaid Services
907 KAR 1:019 & E. Outpatient Pharmacy Program. ("E" expires 7/30/14) (Not Amended After Comments)
907 KAR 1:030 & E. Home health agency services. ("E" expires 7/26/14) (Not Amended After Comments)
907 KAR 1:038 & E. Hearing Program coverage provisions and requirements. ("E" expires 7/26/14) (Amended After Comments)
907 KAR 1:039 & E. Hearing Program reimbursement provisions and requirements. ("E" expires 6/24/14) (Deferred from March)
907 KAR 1:044 & E. Coverage provisions and requirements regarding community mental health center services. ("E" expires 7/30/14) (Amended After Comments)
907 KAR 1:045 & E. Reimbursement provisions and requirements regarding community mental health center services. ("E" expires 7/30/14) (Amended After Comments)
907 KAR 1:054 & E. Coverage provisions and requirements regarding federally-qualified health center services, federally-qualified health center look-alike services, and primary care center services. ("E" expires 7/30/14) (Amended After Comments)
907 KAR 1:082 & E. Coverage provisions and requirements regarding rural health clinic services. ("E" expires 7/30/14) (Amended After Comments)
907 KAR 1:604 & E. Recipient cost-sharing. ("E" expires 7/26/14) (Amended After Comments)
907 KAR 1:631 & E. Vision Program reimbursement provisions and requirements.("E" expires 7/26/14) (Amended After Comments)
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907 KAR 3:005 & E. Coverage of physicians' services. ("E" expires 7/26/14) (Amended After Comments)
Occupational, Physical, and Speech Therapy
907 KAR 8:005 & E. Definitions for 907 KAR Chapter 8. ("E" expires 7/26/14) (Not Amended After Comments)
907 KAR 8:010 & E. Independent occupational therapy service coverage provisions and requirements. ("E" expires 7/26/14) (Not Amended After Comments)
907 KAR 8:015 & E. Independent occupation therapy service reimbursement provisions and requirements. ("E" expires 7/26/14) (Amended After Comments)
907 KAR 8:020 & E. Independent physical therapy service coverage provisions and requirements. ("E" expires 7/26/14) (Not Amended After Comments)
907 KAR 8:025 & E. Physical therapy service reimbursement provisions and requirements. ("E" expires 7/26/14) (Amended After Comments)
907 KAR 8:030 & E. Independent speech pathology service coverage provisions and requirements. ("E" expires 7/26/14) (Not Amended After Comments)
907 KAR 8:035 & E. Speech language pathology service reimbursement provisions and requirements.("E" expires 7/26/14) (Amended After Comments)
Hospital Service Coverage and Reimbursement
907 KAR 10:014 & E. Outpatient hospital service coverage provisions and requirements. ("E" expires 7/26/14) (Amended After Comments)
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907 KAR 13:010 & E. Private duty nursing service coverage provisions and requirements. ("E" expires 7/26/14) (Amended After Comments)
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Behavioral Health
907 KAR 15:005 & E. Definitions for 907 KAR Chapter 15. ("E" expires 7/30/14) (Amended After Comments)
907 KAR 15:010 & E. Coverage provisions and requirements regarding behavioral health services provided by independent providers. (Amended After Comments)
907 KAR 15:015 & E. Reimbursement provisions and requirements for behavioral health services provided by independent providers. ("E" expires 7/30/14) (Amended After Comments)

Department for Behavioral Health, Developmental and Intellectual Disabilities
Division for Behavioral Health

Mental Health
908 KAR 2:240 & E. Kentucky Youth Peer Support Specialist. ("E" expires 8/5/2014) (Deferred from April)
908 KAR 2:250 & E. Community support associate; eligibility criteria and training. ("E" expires 8/5/2014) (Deferred from April)

Department for Aging and Independent Living
Division of Guardianship

Guardianship
910 KAR 2:040. Service provisions for adult guardianship.

Department for Community Based Services
Division of Family Support

K-TAP, Kentucky Works, Welfare to Work, State Supplementation
921 KAR 2:055. Hearings and appeals.
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921 KAR 3:070. Fair hearings.

Commissioner's Office

Child Welfare

922 KAR 1:320. Service appeals.

Division of Protection and Permanency

Child Welfare

922 KAR 1:480. Appeal of child abuse and neglect investigative findings.

REMOVED FROM MAY 2014 AGENDA

GENERAL GOVERNMENT CABINET

Board of Licensure for Massage Therapy

Board

201 KAR 42:035. Application process, exam, and curriculum requirements. (Comments Received, SOC ext.)
201 KAR 42:040. Renewal. (Comments Received, SOC ext.)
201 KAR 42:060. Code of ethics and standards of practice for massage therapists. (Comments Received, SOC ext.)
201 KAR 42:080. Programs of massage therapy instruction. (Comments Received, SOC ext.)
201 KAR 42:110. Continuing education requirements. (Comments Received, SOC ext.)

TRANSPORTATION CABINET

Kentucky Bicycle and Bikeways Commission

Motorcycle and Bicycle Safety

601 KAR 14:020. Bicycle Safety standards. (Comments Received, SOC ext.)

Department of Highways

Division of Maintenance

Billboards

603 KAR 10:001. Definitions. (Amended After Comments) (Deferred from May)
603 KAR 10:010. Static advertising devices. (Amended After Comments) (Deferred from May)
603 KAR 10:020. Electronic advertising devices. (Amended After Comments) (Deferred from May)
603 KAR 10:030. Removal of vegetation related to advertising devices. (Amended After Comments) (Deferred from May)

KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM

Kentucky Fire Commission

Commission on Fire Protection Personnel Standards and Education

739 KAR 2:090. Candidate Physical Ability Test. (Comments Received, SOC ext.)

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Supports for Community Living Waiver

907 KAR 12:020E. Reimbursement for new Supports for Community Living waiver services. ("E" expires 8/5/2014) (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
30 KAR 6:010E

Nature of the emergency: This emergency administrative regulation is being promulgated to implement KRS 14.260-14.318, which creates an address confidentiality program that allows victims of specified crimes to have their names and addresses kept out of publicly available voter records and vote via mail-in absentee ballot. KRS 14.260-14.318 became effective June 25, 2013. There is a primary election scheduled to be held in Kentucky on May 20, 2014. The deadline to register to vote in the May 20, 2014, Primary Election is April 21, 2014. This emergency administrative regulation needs to become effective immediately to protect human health by allowing victims of specified crimes to register to vote and vote in the May 20, 2014, Primary Election without risking their addresses being discovered by the perpetrators of the crimes against them through examination of publicly available voter records or appearance at a polling place. The reasons why an ordinary administrative regulation is not sufficient: An ordinary administrative regulation is not sufficient because it will not enable victims of specified crimes to have their addresses kept out of publicly available voter records and vote via mail-in absentee ballot so that they can register to vote and vote in the May 20, 2014, Primary Election without risking their addresses being discovered by the perpetrators of the crimes against them through examination of publicly available voter records or appearing at a polling place. 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
ALISON LUNDERGAN GRIMES, Secretary of State

OFFICE OF KENTUCKY SECRETARY OF STATE
(New Emergency Administrative Regulation)

30 KAR 6:010E. Kentucky address confidentiality program.

RELATES TO: KRS 14.300, 14.302, 14.304, 14.306, 14.310
STATUTORY AUTHORITY: KRS 14.304(2), (4), 14.306(3), (5), 14.318(2)
EFFECTIVE: March 24, 2014
NECESSITY, FUNCTION, AND CONFORMITY: KRS 14.318(2) authorizes the Secretary of State to promulgate administrative regulations implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation implements KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

Section 1. Definitions. (1) "Address" is defined by KRS 14.300(1).
(2) "Applicant" is defined by KRS 14.300(2).
(3) "Filer" means a person who is:
(a) A:
1. Parent or guardian acting on behalf of a minor;
2. Guardian acting on behalf of a person who is declared incompetent; or
3. Designee of an applicant or a parent or guardian of a minor or a guardian of a person declared incompetent who cannot apply independently; and
(b) Applying to the Secretary of State to have an address designated by the Secretary of State serve for voting purposes as the address of the minor, incompetent person, or applicant.
(4) "Program Participant" is defined by KRS 14.300(5).

Section 2. Requirements for Application for Certification to Participate in the Address Confidentiality Program. (1) Application for certification to participate in the address confidentiality program shall be made to the Secretary of State by submitting a completed Application for Certification to Participate in Address Confidentiality Program.
(2) The Application for Certification to Participate in Address Confidentiality shall be:
(a) Notarized; and
(b) In English.

Section 3. Certification in the Address Confidentiality Program. (1) The Secretary of State shall approve an Application for Certification to Participate in Address Confidentiality Program and certify the applicant as a program participant if the applicant and the Application for Certification to Participate in Address Confidentiality Program meet the requirements established in KRS 14.304 and this administrative regulation.
(2) The Secretary of State shall notify the applicant or filer whether the Application for Certification to Participate in Address Confidentiality Program was denied or the applicant was certified as a program participant.
(a) If an Application for Certification to Participate in Address Confidentiality Program is denied, the Secretary of State shall inform the applicant or filer of the reason for the denial.
(b) If an applicant is certified as a program participant, the Secretary of State shall:
1. Assign to the program participant a participant number and designated address to be used for voting purposes; and
2. Issue to the program participant an Address Confidentiality Program Participant Card reflecting the participant number, designated address to be used for voting purposes, and date on which certification expires.
(3) If an applicant is certified as a program participant, participation in the address confidentiality program shall be effective as of the date of the notification of certification.

Section 4. Change of Program Participant's Name or Address.
(1) A program participant or a filer shall notify the Secretary of State of a change in the program participant's name or address by submitting to the Office of the Secretary of State a completed Address Confidentiality Program Participant Name or Address Change form.
(2) The Address Confidentiality Program Participant Name or Address Change form shall:
(a) Be in writing;
(b) Be in English;
(c) Be signed by the program participant or a filer;
(d) Include both the program participant's new information and information as certified; and
(e) Be considered filed on the day the Address Confidentiality Program Name or Address Change form is date-stamped received by the Office of the Secretary of State.

Section 5. Withdrawal from Participation in the Address Confidentiality Program. (1) A program participant or filer wishing to withdraw from participation in the address confidentiality program shall submit to the Secretary of State a Withdrawal from Participation in Address Confidentiality Program form.
(2) The Withdrawal from Participation in Address Confidentiality Program form shall be:
(a) In writing;
(b) In English;
(c) Signed by the program participant or a filer;
(d) Notarized or signed by a representative of any office designated pursuant to KRS 14.310 as a referring agency who assisted in the completion of the Withdrawal from Participation in Address Confidentiality Program form; and
(e) Submitted to the Secretary of State by mail or in person.

Section 6. Confirmation by the Secretary of State of a Withdrawal from Participation in the Address Confidentiality Program. (1) Upon receiving a Withdrawal from Participation in Address Confidentiality Program form, the Secretary of State shall mail to the program participant or filer a written confirmation of withdrawal.

(2) The written confirmation shall notify the program participant or filer:

(a) Of the date on which a Withdrawal from Participation in Address Confidentiality Program form was date stamped received by the Office of the Secretary of State; and

(b) That program participation shall be terminated ten (10) days following the date of the written confirmation of withdrawal, unless the program participant or a filer notifies the Secretary of State on or before that date that the withdrawal request was not legitimate because it was not voluntarily submitted by the program participant or a filer.

Section 7. Application for Renewal of Certification in the Address Confidentiality Program. (1) A program participant or filer wishing to renew certification in the address confidentiality program shall submit to the Secretary of State at least five (5) business days prior to the date on which the program participant's certification expires an Application for Certification to Participate in Address Confidentiality Program pursuant to Section 2 of this administrative regulation.

(2) The Application for Certification to Participate in Address Confidentiality Program shall be considered timely submitted for purposes of renewal if it is date-stamped received by the Office of the Secretary of State at least five (5) business days prior to the date on which the program participant's certification expires.

Section 8. Review by the Secretary of State of a Renewal Application for Certification to Participate in Address Confidentiality Program. (1) The Secretary of State shall approve a renewal Application for Certification to Participate in Address Confidentiality Program if the applicant and Application for Certification to Participate in Address Confidentiality Program meet the requirements established in KRS 14.304 and this administrative regulation.

(2) The Secretary of State shall notify the program participant or filer whether the renewal Application for Certification to Participate in Address Confidentiality Program was denied or the program participant's certification was renewed within five (5) business days after it is date-stamped received by the Secretary of State.

(a) If a renewal Application for Certification to Participate in Address Confidentiality Program is denied, the Secretary of State shall inform the program participant or filer of the reason for denial.

(b) If a program participant's certification is renewed, the Secretary of State shall issue to the program participant a new Address Confidentiality Program Participant Card pursuant to Section 3(2)(b)2 of this administrative regulation, and the renewal shall be effective as of the date of the notification of renewal.

Section 9. Appeal from Cancellation of Certification in Address Confidentiality Program. (1) A program participant or filer wishing to appeal from a cancellation of certification in the address confidentiality program shall submit to the State Board of Elections an Appeal from Cancellation of Certification in Address Confidentiality Program form.

(2) The Appeal from Cancellation of Certification in Address Confidentiality Program shall be considered timely submitted if it is date-stamped received by the State Board of Elections within thirty (30) days of the date of the notice of certification cancellation.

(3) The Appeal from Cancellation of Certification in Address Confidentiality Program shall:

(a) Be in writing;

(b) Be in English;

(c) Be signed by the program participant or filer; and

(d) Include information as to why certification in the address confidentiality program should not be cancelled.

(4) If an Appeal from Cancellation of Certification in Address Confidentiality Program is not timely submitted, cancellation of certification in the address confidentiality program shall be effective upon the expiration of thirty (30) days after the date of the notice of certification cancellation.

Section 10. Review by the Executive Director of the State Board of Elections of an Appeal from Cancellation of Certification in Address Confidentiality Program. (1) The executive director of the State Board of Elections shall approve or deny an Appeal from Cancellation of Certification in Address Confidentiality Program within five (5) business days after it is date-stamped received by the State Board of Elections.

(a) The executive director of the State Board of Elections shall approve an Appeal from Cancellation of Certification in Address Confidentiality Program if the executive director determines that grounds for cancellation pursuant to KRS 14.306 do not exist.

(b) The executive director of the State Board of Elections shall deny an Appeal from Cancellation of Certification in Address Confidentiality Program if the executive director determines that grounds for cancellation pursuant to KRS 14.306 exist.

(2) The executive director of the State Board of Elections shall provide to the program participant or filer written notice of the decision regarding an Appeal from Cancellation of Certification in Address Confidentiality Program.

(3) If an Appeal from Cancellation of Certification in Address Confidentiality Program is timely submitted and denied pursuant to this section, cancellation of certification in the address confidentiality program shall be effective on the date on which the notice of denial is mailed.

(4) The decision of the executive director of the State Board of Elections shall conclude the appeal procedures pursuant to KRS Chapter 14 and this administrative regulation.

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

(a) "Application for Certification to Participate in Address Confidentiality Program," March 2014;

(b) "Address Confidentiality Program Participant Card," March 2014;

(c) "Address Confidentiality Program Participant Name or Address Change," March 2014;

(d) "Withdrawal from Participation in Address Confidentiality Program," March 2014; and

(e) "Appeal from Cancellation of Certification in Address Confidentiality Program," March 2014.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Secretary of State's Office, 700 Capital Avenue, State Capitol, Suite 152, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or may be obtained at http://www.sos.ky.gov.

ALISON LUNDERGAN GRIMES, Secretary of State

APPROVED BY AGENCY: March 24, 2014

FILED WITH LRC: March 24, 2014 at 2 p.m.

CONTACT PERSON: Lindsay Hughes Thurston, Assistant Secretary of State, 700 Capital Ave., Ste. 152, Frankfort, Kentucky 40601, phone (502) 564-3490, fax (502) 564-5687.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lindsay Hughes Thurston

(1) Provide a brief narrative summary of:

(a) What this administrative regulation does: KRS 14.318 authorizes the Secretary of State to promulgate administrative regulations implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation implements KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to implement KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 14.318 authorizes the Secretary of State to promulgate administrative regulations implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation implements KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

(d) How this administrative regulation will assist in the effective administration of the statutes: KRS 14.318 authorizes the Secretary of State to promulgate administrative regulations

implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation assists in the effective administration of the statutes by implementing KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

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

(a) How the amendment will change the existing administrative regulation: This 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 an unknown number of victims of specified crimes who wish to keep confidential their addresses, address confidentiality program participants, the Office of the Secretary of State, the State Board of Elections, and referring agencies designated under KRS 14.310.

(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: Victims of specified crimes are not required to take any action to comply with this administrative regulation but will have the opportunity to have their addresses kept out of publicly available voter records and vote via mail-in absentee ballot by following the procedures set forth in this administrative regulation. Program participants will be required to follow the procedures established in this administrative regulation for notifying the Office of the Secretary of State of a change of name or address, withdrawing from the address confidentiality program, renewing certification to participate in the address confidentiality program, and appealing a cancellation of certification to participate in the address confidentiality program. In order to comply with this administrative regulation, the Office of the Secretary of State, State Board of Elections, and referring agencies designated under KRS 14.310 will need to familiarize themselves with the procedures and forms set forth in this administrative regulation. The Office of the Secretary of State and State Board of Elections will also be required to process forms submitted by applicants, filers, and program participants 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 victims of specified crimes, program participants, or referring agencies designated under KRS 14.310 to comply with this administrative regulation. The cost, if any, to the Office of the Secretary of State and State Board of Elections to comply with this administrative regulation will be de minimis.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Voting records, including voters' names and addresses, are matters of public record. In some instances, victims of specified crimes who are otherwise eligible to register to vote and vote do not do so because they fear the perpetrators of the crimes against them would be able to determine their addresses or voting precincts, compromising their safety or the safety of their children. As a result of compliance with this administrative regulation, victims of specified crimes will be able to have their addresses kept out of publicly available voter records and vote via mail-in absentee ballot so that they can register to vote and vote without their addresses or voting precincts being discovered. The Office of the Secretary of State and State Board of Elections have an interest in ensuring that all eligible Kentuckians are able to exercise the right to vote, and compliance with this administrative regulation furthers that interest by enabling victims of specified crimes to register to vote and vote without fear that the perpetrators of the crimes against them will be able to determine their addresses or voting precincts. Referring agencies designated under KRS 14.310 will benefit from the extension and enhancement of their efforts to ensure the safety of victims of specified crimes.

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

(a) Initially: Ordinary printing and personnel costs already anticipated in budget.

(b) On a continuing basis: Ordinary printing and personnel costs already anticipated in budget.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Secretary of State and/or State Board of Elections' budget.

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

(9) TIERING: Is tiering applied? Tiering was not applied because this administrative regulation applies equally to all individuals affected.

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 Office of the Secretary of State and State Board of Elections.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: This administrative regulation is authorized by KRS 14.318(2), 14.304(1), 14.304(4), 14.306(3), and 14.306(5).

(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 additional revenue for state or local governments during the first year.

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

(c) How much will it cost to administer this program for the first year? The cost, if any, to state and local governments to administer this program for the first year will be de minimis.

(d) How much will it cost to administer this program for subsequent years? The cost, if any, to state and local governments to administer this program for subsequent years will be de minimis.

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 18:001E

This emergency administrative regulation is being promulgated to establish the definitions for 907 KAR Chapter 18. 907 KAR Chapter 18 contains a companion administrative regulation - 907 KAR 18:005E, Reimbursement provisions and requirements regarding Veterans Affairs nursing facilities - that is being promulgated concurrently with this administrative regulation. The aforementioned companion administrative regulation establishes Medicaid Program reimbursement of nursing facility services provided by Veterans Affairs (VA) nursing facilities. Covering VA nursing facility services in the Medicaid program is necessary to maintain the viability of VA nursing facilities in Kentucky and to ensure access to such health care for Kentucky's veterans. This action must be taken on an emergency basis to protect the health, safety, and welfare of Kentucky veterans to ensure that they have access to nursing facility services provided by Veterans Affairs nursing facilities in Kentucky. 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
APPROVED BY AGENCY: March 7, 2014
FILED WITH LRC: March 24, 2014 at 4 p.m.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(New Emergency Administrative Regulation)

907 KAR 18:001E. Definitions for 907 KAR Chapter 18.

RELATES TO: 42 U.S.C. 1396a(a)(13)(A), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. Part 413, 42 C.F.R. 447.204
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)
EFFECTIVE: March 24, 2014
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 definitions for 907 KAR Chapter 18.

Section 1. Definitions. (1) "Allowable cost" means that portion of a facility's cost which may be allowed by the department for reimbursement purposes.
(2) "Ancillary service" means an ancillary service as established in 907 KAR 1:023.
(3) "Capital costs" means capital costs as established in 42 C.F.R. 413.130 through
157.
(4) "Cost report" means a copy of the cost report that a VA NF submits to the Medicare program.
(5) "Department" means the Department for Medicaid Services or its designee.
(6) "Federal financial participation" is defined by 42 C.F.R. 400.203.
(7) "Global Insight Index" means an indication of changes in health care costs from year to year developed by Global Insights Index.
(8) "Pro forma cost data" means estimated cost data for a specific future period of time.
(9) "Prospective payment rate" means a payment rate for services based on allowable costs and other factors.
(10) "Recipient" is defined by KRS 205.8451(9).
(11) "State fiscal year" means the twelve (12) month period beginning on July 1 of one year and ending on June 30 of the following year.
(12) "Upper payment limit" means an amount of reimbursement that:
(a) Equates to a Veterans Affairs nursing facility's Medicaid-allowable cost; and
(b) Does not exceed the limit established in 42 C.F.R. 447.272.
(13) "VA NF" means a nursing facility that is currently:
(a) Licensed by the Cabinet for Health and Family Services, Office of Inspector General as a nursing facility;
(b) Approved by the department for Medicaid program participation; and
(c) Certified by the United States Department of Veterans Affairs as a state veterans home.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary
APPROVED BY AGENCY: March 7, 2014
FILED WITH LRC: March 24, 2014 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, tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations in 907 KAR Chapter 18. Chapter 18 contains an administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding Veterans Affairs nursing facility services.
(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the definitions for administrative regulations in 907 KAR Chapter 18.
(c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for administrative regulations in 907 KAR Chapter 18.
(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 the definitions for administrative regulations in 907 KAR Chapter 18.
(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: Veterans Affairs nursing facilities will be affected by the administrative regulation. Currently, there are three (3) such facilities operating in Kentucky – the Eastern Kentucky Veterans Center in Hazard, KY; the Thomson-Hood Veterans Center in Wilmore, KY; and the Western Kentucky Veterans Center in Hanson, KY. A fourth is scheduled to open in the autumn of 2015 in Radcliff, KY.
(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 as this administrative regulation establishes definitions for 907 KAR

Chapter 18.

(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 administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Veterans Affairs nursing facilities will be benefit due to the clarity resulting from terms being defined in an administrative regulation.

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

(a) Initially: No cost is necessary to implement this administrative regulation.

(b) On a continuing basis: No 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: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the 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. 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 amendment neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the definitions apply equally to all entities regulated by this administrative regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

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

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

(c) How much will it cost to administer this program for the first year? DMS estimates that not cost is needed to implement this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that no cost is needed 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 18:005E

This emergency administrative regulation is being promulgated to establish Medicaid Program reimbursement of nursing facility services provided by Veterans' Affairs (VA) nursing facilities. Covering VA nursing facility services in the Medicaid program is necessary to maintain the viability of VA nursing facilities in Kentucky and to ensure access to such health care for Kentucky's veterans. This action must be taken on an emergency basis to protect the health, safety, and welfare of Kentucky veterans to ensure that they have access to nursing facility services provided by Veterans' Affairs nursing facilities in Kentucky. 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 18:005E. Reimbursement provisions and requirements regarding Veterans Affairs nursing facility services.

RELATES TO: 42 U.S.C. 1396a(a)(13)(A), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. Part 413, 42 C.F.R. 447.204

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

EFFECTIVE: March 24, 2014

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 Department for Medicaid Services' reimbursement provisions and requirements regarding Veterans Affairs nursing facility services in Kentucky.

Section 1. Provider Participation. To be eligible to be reimbursed for services under this administrative regulation, a VA NF shall be currently:

(1) Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(2) Participating in the Kentucky Medicaid Program in accordance with 907 1:671;

(3) Licensed by the Cabinet for Health and Family Services, Office of Inspector General as a nursing facility; and

(4) Certified as a state veterans home by the United States Department of Veterans Affairs.

Section 2. General Requirements. To be reimbursable by the department, a service shall be:

(1) Medically necessary;

(2) Provided to a recipient who is eligible for nursing facility services in accordance with 907 KAR 1:022;

(3) Provided in accordance with 907 KAR 1:022; and

(4) Provided by a VA NF that meets the requirements established in Section 1 of this administrative regulation.

Section 3. Covered Services. The following services, if provided by a VA NF in accordance with this administrative regulation, shall be covered under this administrative regulation:

(1) Nursing facility services;

(2) Ancillary services;

(3) Laboratory procedures or radiological services if ordered by a:

1. Physician;

2. An advanced practice registered nurse if the laboratory test or radiological service is within the scope of the advance practice registered nurse's practice; or

3. Physician assistant if:

a. Authorized by the supervising physician; and

b. The laboratory test or radiological service is within the scope of the physician assistant's practice; or

(4) Psychological or psychiatric therapy.

Section 4. Reimbursement. (1) The department shall reimburse a VA NF for services under this administrative regulation on a cost basis.

(2)(a) The cost basis shall include reimbursing:

1. A VA NF for services on an interim basis during a state fiscal year using a prospective payment rate; and

2. A final reimbursement to a VA NF for services for a state fiscal year:

a. Equal to the VA NF's Medicaid allowable cost for the state fiscal year; and

b. That results from a reconciliation of the:

(i) Interim prospective reimbursement paid by the department to the VA NF for the state fiscal year; and

(ii) Actual Medicaid allowable costs experienced by the VA NF for the state fiscal year as reflected on the cost report that has been desk reviewed and approved by the department for the state fiscal year.

(b)1. The prospective payment rate referenced in paragraph (a)1 of this subsection shall be:

a. Established using the most recently submitted cost report available to and reviewed by the department as of May 16 prior to the beginning of the state fiscal year; and

b. Trended and indexed to the midpoint of the state fiscal year.

2. For example, to set a prospective payment for a VA NF effective July 1, 2014, for the state fiscal year beginning July 1, 2014, the department shall:

a. Use the most recently submitted cost report available to the department as of May 16, 2013; and

b. Trend and index the prospective payment rate to December 31, 2013.

(3)(a) A prospective payment rate for services shall:

1. Be specific to the VA NF;

2. Not be subject to retroactive adjustment except as specified in this section;

3. Be determined by the department on a cost basis annually; and

4. Except as established in paragraph (b) of this subsection, be based on a VA NF's Medicaid allowable costs.

(b)1. If no cost report containing a full state fiscal year of cost data for a VA NF is available as of May 16, to set a prospective payment rate for the VA NF, the department shall:

a. If at least six (6) months of cost data is available, use pro forma cost data:

(i) Submitted to the department by the VA NF; and

(ii) Approved by the department; or

b. If less than six (6) months of cost data is available, establish a prospective payment rate equal to the statewide average prospective payment rate of existing VA NFs until the department receives a pro forma cost data including at least six (6) months of cost data.

2. Pro forma cost data shall be trended and indexed in the same way as established in subsection (2)(b) of this section.

(c) The department may adjust a prospective payment rate during the state fiscal year if the prospective payment rate that was established appears likely to result in a substantial cost settlement that could be avoided by adjusting the prospective payment rate.

(d)1. If the latest available cost report data has not been audited or desk-reviewed prior to rate setting for the universal year beginning July 1, a prospective rate based on a cost report which has not been audited or desk-reviewed shall be subject to adjustment when the audit or desk review is completed.

2. An unaudited cost report shall be subject to an adjustment to the audited amount after auditing has occurred.

(e)1. If the department has made a separate rate adjustment as compensation to a VA NF for a minimum wage update, the department shall:

a. Not pay the VA NF twice for the same costs; and

b. Adjust downward the trending and indexing factors to the extent necessary to remove from the factors costs relating to the minimum wage updates already provided for by the separate rate adjustment.

2. If the trending and indexing factors include costs related to a minimum wage increase:

a. The department shall not make a separate rate adjustment; and

b. The minimum wage costs shall not be deleted from the trending and indexing factors.

(4) The department shall consider an adjustment to a VA NF's prospective rate (subject to the upper payment limit) if:

(a) The VA NF's increased costs are attributable to:

1. A governmentally imposed minimum wage increase, staffing ratio increase, or a level of service increase; and

2. The increase was not included in the Global Insight Index;

(b) A new licensure requirement or new interpretation of an existing requirement by the appropriate governmental agency as issued in an administrative regulation results in changes that affect all VA NFs; or

(c) The VA NF experiences a governmentally-imposed displacement of residents.

(5)(a) The amount of any prospective payment rate adjustment resulting from a governmentally-imposed minimum wage increase or licensure requirement change or interpretation as cited in subsection (4) of this section shall not exceed the amount by which the cost increase resulting directly from the governmental action exceeds on an annualized basis the inflation allowance amount included in the prospective rate for the general cost area in which the increase occurs.

1. For purposes of this determination, costs shall be classified as either:

a. Salaries; or

b. Other.

2. The effective date of an interim rate adjustment shall be the first day of the month in which the adjustment is requested or in which the cost increase occurred, whichever is later.

(6) A year-end adjustment of a prospective rate and a retroactive cost settlement adjustment shall be made if:

(a) An incorrect payment has been made due to a computational error (other than an omission of cost data) discovered in the cost basis or establishment of the prospective rate;

(b) An incorrect payment has been made due to a misrepresentation on the part of a facility (whether intentional or unintentional);

(c) A facility is sold and the funded depreciation account is not transferred to the purchaser; or

(d) The prospective rate has been set based on unaudited cost reports and the prospective rate is to be adjusted based on audited reports with the appropriate cost settlement made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.

(7)(a) The department shall retroactively cost settle reimbursement for services.

(b) Retroactive settlement shall entail:

1. Comparing interim prospective payments with the properly apportioned cost of Medicaid services rendered;

2. A tentative cost report settlement based upon:

a. Eighty (80) percent of any amount due the facility after a preliminary review is performed; or

b. 100 percent settlement of any liability due the department; and

3. A final cost report settlement after the allowed billing period has elapsed for the dates of service identified within the cost report.

(c) To be considered final, a cost report shall have been reviewed and approved by the department.

Section 5. Allowable and Non-allowable Costs. (1) Nursing facility services costs shall be the direct costs associated with nursing facility services.

(2)(a) Except as provided in paragraph (d) of this subsection, interest expense used in setting a prospective rate shall be an allowable cost if:

1. Permitted pursuant to 42 C.F.R. 413.153; and

2. The interest expense:

a. Represents interest on:

(i) Long term debt existing at the time the provider enters the program; or

(ii) New long-term debt, if the proceeds are used to purchase fixed assets relating to the provision of the appropriate level of care; or

b. Is for working capital and operating needs that directly relate to providing patient care.

(b) The forms of indebtedness may include:

1. Notes, advances, and various types of receivable financing; or

2. Mortgages, bonds, and debentures if the principal is to be repaid over a period in excess of one (1) year.

(c) If a debt is subject to variable interest rates found in balloon-type financing, renegotiated interest rates shall be allowable.

(d) Interest on a principal amount used to purchase goodwill or other intangible assets shall not be considered an allowable cost.

(3)(a) The allowable cost for a service or good purchased by a VA NF from a related organization shall be the cost to the related organization unless it can be demonstrated that the related organization is equivalent to a second party supplier.

(b) Except as provided in paragraph (c) of this subsection, an organization shall be considered a related organization if an individual possesses five (5) percent or more of ownership or equity in the facility and the supplying business.

(c) An organization shall not be considered a related organization if fifty-one (51) percent or more of the supplier's business activity of the type carried on with the VA NF is transacted with persons and organizations other than the VA NF and its related organizations.

(4) The amount allowable for leasing costs shall not exceed the amount which would be allowable based on the computation of historical costs.

(5) A cost shall be allowable and eligible for reimbursement if the cost is:

(a) Reflective of the provider's actual expenses of providing a service; and

(b) Related to Medicaid patient care pursuant to 42 C.F.R. 413.9.

(6) The following costs shall be allowable:

(a) Costs to related organizations pursuant to 42 C.F.R. 413.17;

(b) Costs of educational activities pursuant to 42 C.F.R. 413.85;

(c) Research costs pursuant to 42 C.F.R. 413.90;

(d) Value of services of nonpaid workers pursuant to 42 C.F.R. 413.94;

(e) Purchase discounts and allowances pursuant to 42 C.F.R. 413.98;

(f) Refunds of expenses pursuant to 42 C.F.R. 413.98;

(g) Depreciation on buildings and equipment if a cost is:

1. Identifiable and recorded in the provider's accounting records;

2. Based on historical cost of the asset or, if donated, the fair market value; or

3. Prorated over the estimated useful life of the asset using the straight-line method;

(h) Interest on current and capital indebtedness;

(i) Professional costs of services of full-time or regular part-time employees not to exceed what a prudent buyer would pay for comparable services; or

(j) A provider tax on a VA NF.

(7) The following costs shall not be allowable:

(a) The value of services provided by nonpaid members of an organization if there is an agreement with the provider to furnish the services at no cost;

(b) Political contributions;

(c) Legal fees for unsuccessful lawsuits against the Cabinet for Health and Family Services;

(d) Travel and associated costs outside of the Commonwealth of Kentucky to conventions, meetings, assemblies, conferences, or any related activities that are not related to NF training or educational purposes; or

(e) Costs related to lobbying.

(8) To determine the gain or loss on the sale of a facility for purposes of determining a purchaser's cost basis in relation to depreciation and interest costs, the following methods shall be used for changes of ownership occurring before July 18, 1984:

(a)1. Determine the actual gain on the sale of the facility; and

2. Add to the seller's depreciated basis two-thirds (2/3) of one (1) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller to arrive at the purchaser's cost basis;

(b) Gain shall be the amount in excess of a seller's depreciated basis as computed under program policies at the time of a sale, excluding the value of goodwill included in the purchase price;

(c)1. A sale shall be any bona fide transfer of legal ownership from an owner to a new owner for reasonable compensation, which shall usually be fair market value; and

2. A lease purchase agreement or other similar arrangement which does not result in a transfer of legal ownership from the original owner to the new owner shall not be considered a sale until legal ownership of the property is transferred; and

(d) If an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the purchaser's cost basis shall be determined pursuant to paragraphs (a) through (c) of this subsection.

(9)(a) An increase in valuation in relation to depreciation and interest costs shall not be allowed for changes of ownership occurring after July 18, 1984, and before October 1, 1985.

(b) For bona fide changes of ownership entered into on or after October 1, 1985, the depreciation and interest costs shall be increased in valuation in accordance with 42 U.S.C. 1395x(v)(1)(O)(i).

(10)(a) Maximum allowable costs shall be the maximum amount which may be allowed to a VA NF as reasonable cost for the provision of a supply or service while complying with limitations expressed in related federal or state regulations.

(b) Costs shall be subject to allowable cost limits pursuant to 42 C.F.R. 413.106.

Section 6. Cost Report Requirements. (1)(a) A VA NF shall, no later than five (5) months following the end of a state fiscal year, submit to the department a cost report stating the VA NF's costs for the state fiscal year.

(b) The time limit stated in paragraph (a) of this subsection may be extended at the specific request of the facility with the department's concurrence.

(2) If the VA NF experienced a new item or expansion representing a departure from current service levels and for which the VA NF requested prior approval by the department, the VA NF shall submit a supplement to the cost report to the department which:

(a) Describes the new item or expansion; and

(b) States the rationale for the new item or expansion.

(3)(a) Department approval or rejection of a projection or expansion shall be made on a prospective basis in the context that if an expansion and related costs are approved they shall be considered when actually incurred as an allowable cost.

(b) Rejection of an item or costs shall represent notice that the costs shall not be considered as part of the cost basis for reimbursement.

(c) Unless otherwise specified, approval shall relate to the substance and intent rather than the cost projection.

(d) If a request for prior approval of a projection or expansion is made, absence of a response by the department shall not be construed as approval of the item or expansion.

(4)(a) The department shall perform a desk review of each cost report to determine whether an audit is necessary and, if so, the scope of the audit.

(b) If the department determines that an audit is not necessary, the cost report shall be settled without an audit.

(c) A desk review or audit shall be used for purposes of verifying cost to be used in setting the prospective rate or for purposes of adjusting prospective rates which have been set based on unaudited data.

(d) Audits may be conducted annually or at less frequent intervals.

(5)(a) A VA NF shall maintain and make available any records and data necessary to justify and document:

1. Costs to the VA NF; and
2. Services performed by the VA NF.

(b) The department shall have unlimited on-site access to all of a VA NF's fiscal and service records for the purpose of:

1. Accounting;
2. Auditing;
3. Medical review;
4. Utilization control; or
5. Program planning.

Section 7. Preadmission Screening Resident Review (PASRR). (1) Prior to an admission of an individual to a VA NF, a VA NF shall conduct a level I PASRR in accordance with 907 KAR 1:755.

(2)(a) The department shall not reimburse a VA NF for a service delivered to an individual if the VA NF did not comply with the requirements of 907 KAR 1:755.

(b) Failure to comply with 907 KAR 1:755 may be grounds for termination of a VA NF's participation in the Medicaid Program.

Section 8. No Duplication of Service. The department shall not reimburse for a service provided by a VA NF to a recipient if the same service is provided at the same time to the recipient by another Medicaid program provider.

Section 9. Records Maintenance, Protection, and Security. (1)(a) A VA NF 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 VA NF 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 VA NF shall comply with 45 C.F.R. Part 164.

Section 10. Medicaid Program Participation Compliance. (1) A VA NF 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 VA NF receives any duplicate payment or overpayment from the department, regardless of reason, the VA NF 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 11. Third Party Liability. A VA NF shall comply with KRS 205.622.

Section 12. 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 VA NF 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 VA NF'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 VA NF's electronic signature policy;
2. The signed consent form; and
3. The original filed signature immediately upon request.

Section 13. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 14. Federal Approval and Federal Financial Participation. The department's reimbursement and coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement and coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement and coverage.

Section 15. Drug Reimbursement. Drugs to a recipient in a VA NF shall:

(1) Be reimbursed via the department's outpatient pharmacy program in accordance with 907 KAR 1:018;

(2) Not be included in VA NF Medicaid allowable costs; and

(3) Not be reimbursed pursuant to this administrative regulation.

Section 16. Appeal Rights. A participating VA NF may appeal a department decision as to the application of this administrative regulation as it impacts the VA NF's reimbursement in accordance with 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: March 7, 2014

FILED WITH LRC: March 24, 2014 at 4 p.m.

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: 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 regarding Veterans' Affairs nursing facility services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish DMS's reimbursement provisions and requirements regarding Veterans' Affairs nursing facility services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by establishing DMS's

reimbursement provisions and requirements regarding Veterans' Affairs nursing facility 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 DMS's reimbursement provisions and requirements regarding Veterans' Affairs nursing facility 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: Veterans' Affairs nursing facilities will be affected by the amendment. Currently, there are three (3) such facilities operating in Kentucky – the Eastern Kentucky Veterans' Center in Hazard, KY; the Thomson-Hood Veterans Center in Wilmore, KY; and the Western Kentucky Veterans' Center in Hanson, KY. A fourth is scheduled to open in the autumn of 2015 in Radcliff, KY.

(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. Any Veterans' Affairs nursing facility which wishes to be reimbursed by the Kentucky Medicaid program must enroll with the Medicaid program by completing a provider agreement application and performing the actions required in the agreement. To be reimbursed for services VA nursing facilities will have to submit a cost report (documenting the facility's cost) to the department annually.

(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; however, a facility will experience administrative cost related to staff time involved in completing Medicaid program provider agreement.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Veterans' Affairs nursing facilities will be benefit by being reimbursed for services provided to Medicaid recipients and on a cost basis.

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

(a) Initially: The Kentucky Office of Veterans' Affairs (KOVA) will provide the state matching funds necessary to procure federal Medicaid funds; thus, the Department for Medicaid Services (DMS) will experience no cost to implement this administrative regulation. DMS projects annual expenditures in aggregate for the three (3) existing Veterans' Affairs nursing facilities in Kentucky to be approximately $20.04 million ($6.01 million state funds/$14.03 million federal funds.)

(b) On a continuing basis: The response in (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: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the 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. 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 not applied as the provisions and requirements apply equally to all Veterans' Affairs nursing facilities.

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)(13)(A), and 42 C.F.R. 447.204.

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.

3. Minimum or uniform standards contained in the federal mandate. 42 U.S. C. 1396a(a)(30)(A) 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 1396b(i)(4) of this title) 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." 42 U.S.C. 1396a(a)(13)(A) requires "a public process for determination of rates of payment" for nursing facility services and services for intermediate care facilities for individuals with an intellectual disability. 42 C.F.R. 447.204 requires Medicaid programs' reimbursement to be "sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services 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? This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Neither stricter nor additional standards nor responsibilities are 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 the Kentucky Department of Veterans' Affairs 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 and 42 C.F.R. 447.204 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? The amount of revenues that the Veterans' Affairs nursing facilities in Kentucky will receive as a result of this administrative regulation is indeterminable due to the associated variables. A given facility's reimbursement will be based on their Medicaid allowable costs and that won't be accurately known until a facility experiences a full year of costs. Costs will depend on utilization including the number of Medicaid recipients receiving services during the state fiscal year from the given facility. Another variable is how soon a given facility enrolls in the Medicaid program.

(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 in (a) above also applies here.

(c) How much will it cost to administer this program for the first year? The Kentucky Office of Veterans' Affairs (KOVA) will provide the state matching funds necessary to procure federal Medicaid funds; thus, the Department for Medicaid Services (DMS) will experience no cost to implement this administrative regulation. DMS projects annual expenditures in aggregate for the three (3) existing Veterans' Affairs nursing facilities in Kentucky to be approximately $20.04 million ($6.01 million state funds/$14.03 million federal funds.)

(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:

ADMINISTRATIVE REGULATIONS AS AMENDED BY PROMULGATING AGENCY AND REVIEWING SUBCOMMITTEE

ARRS = Administrative Regulation Review Subcommittee
IJC = Interim Joint Committee

OFFICE OF THE GOVERNOR
Department for Local Government
(As Amended at ARRS, April 14, 2014)

109 KAR 16:010. Special purpose governmental entities.

RELATES TO: KRS 65A.010, 65A.020, 65A.030, 65A.040, ***65A.050,*** 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 ***Special Purpose Governmental Entity (SPGE) Financial Disclosure Report,*** 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) ***Each[All]*** special purpose governmental ***entity[~~entities~~]*** in existence prior to December 31, 2013 shall, prior to December 31, 2013, complete and submit ***the[~~DLG Form SPGE 100~~]*** Special Purpose Governmental Entity ***(SPGE)*** Registration and Board Reporting Form***, DLG Form SPGE 100***.

(a) The information shall be submitted in the same manner as required by Section 3(1) of this administrative regulation.

(b) The DLG may allow an alternative form of submission as ***established[~~provided~~]*** in Section 3(2) of this administrative regulation.

(c) 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 ***(SPGE)*** Registration and Board Reporting Form***, DLG Form SPGE 100,*** within fifteen (15) days of the establishment of the entity. The form shall be submitted as ***established[~~provided~~]*** in subsection (1) of this section.

Section 3. Electronic Submission Required; Exceptions. (1) Except as ***established[~~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 ***the Special Purpose Governmental Entity (SPGE) Registration and Board Reporting Form,*** DLG Form SPGE ***100[~~101~~]***.

(2) The SPGE shall submit the budget information required by KRS ***65A.020(2)(a)2.[~~65A.020(2)(a)1~~]*** using ***the Special Purpose Governmental Entity (SPGE) Financial Disclosure Report,*** 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 ***the Special Purpose Governmental Entity (SPGE) Financial Disclosure Report, DLG Form*** 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 ***the Special Purpose Governmental Entity (SPGE) Financial Disclosure Report,*** 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.[~~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.[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.[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.[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.[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 ***established[provided]*** in subsection (5) of this section, an audit shall be conducted on a modified cash basis of accounting as ***referenced[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 ***pursuant to[under]*** the modified cash basis of accounting ***referenced[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 ***(4)[(3)]*** of this section, an audit may be conducted ***pursuant to[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)***1.*** The amount paid by each special purpose governmental entity shall be based on annual revenues of the special purpose governmental entity.

2. 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 ***pursuant to[under]*** subsections (2) and (3) of this section.

(c) Payment shall be accompanied by a completed ***Special Purpose Governmental Entity (SPGE) Financial Disclosure Report,*** DLG Form SPGE 101.

(2) A special purpose governmental entity may request permission to pay the registration fee by alternative means***. The request shall be made in writing and shall include[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. ***A[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 ***Chapter 65A[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.

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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 of Barbering to promulgate administrative regulations pertaining to exam requirements. This administrative regulation establishes the requirements for an examinee who fails one (1) or more portions of the probationary examination and wishes to retake the exam[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 ***may[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)***1. If an applicant has failed one (1) or more portions of the probationary examination two (2) consecutive times, the applicant shall be required to:***

a. Return to school for eighty (80) additional hours of training; and

b. Retake the entire examination.

2. Each unsuccessful attempt to pass the examination thereafter shall require the applicant to complete the conditions delineated in subparagraph 1. of this paragraph[~~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***, in accordance with[~~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.

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.

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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 of Barbering[~~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 ***relicensing*** 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, ***an applicant for relicensure shall meet*** 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) ***To regain a probationary license,*** a probationary[~~An apprentice~~] barber shall[~~must~~]***:***

(a) Complete 150 additional hours in training in an accredited school of barbering***;*** and

(b) 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***, in accordance with 201 KAR 14:115[~~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.

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.

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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 317.440(1) requires the Board of Barbering to promulgate administrative regulations governing the location and housing of barber shops or schools and the quantity and quality of equipment, supplies, materials, records, and furnishings required in barber shops or schools.*** 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 ***contract owner[~~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 ***contract owner[~~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. ***This section shall not apply to violations committed by an independent contract owner, in accordance with KRS 317.595(2).***

FRANCIS L. SIMPSON, Chair

APPROVED BY AGENCY: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

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.

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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)[~~(c)~~]

NECESSITY, FUNCTION, AND CONFORMITY: KRS

317.450(1)(a)-(d)[~~317.440(1)(c),~~] ***requires the Board of Barbering[~~authorizes the board~~]*** to issue probationary licenses before issuing a license to practice barbering. KRS 317.440(1)(d) ***requires[~~authorizes~~]*** the board to ***promulgate administrative regulations establishing[~~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 ***shall meet the qualifications listed in KRS 317.450(1)(a)[~~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 ***a school of barbering approved in accordance with 201 KAR 14:095[~~an approved school of barbering~~]***[obtaining a Kentucky apprentice barber license].

Section 3. (1) A probationary licensee[~~An apprentice barber~~] shall ***not*** apply for a barber license ***until the probationary period required by KRS 317.450 has been served[~~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.

Section 5. (1) The application for licensure shall include the following information:

(a) The applicant's:

1. Name;

2. Address;

3. County;

4. Phone number; and

5. Email address; and

(b) The barber shop's:

1. Name;

2. Address; and

3. Phone number.

(2) The application shall contain the question, "Are you in arrears or default on a repayment obligation under any financial assistance program with the Kentucky Higher Education Assistance Authority?"

(3) The application shall be signed by the applicant.

FRANCIS L. SIMPSON, Chair

APPROVED BY THE BOARD: January 13, 2014

FILED WITH LRC: January 14, 2014 at 8 a.m.

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.

GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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. ***(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 ***201 KAR Chapter 14[~~the various administrative regulations adopted pursuant thereto~~]***, shall**,** upon payment of the ***fee required by 201 KAR 14:180,[~~required fee~~]*** be granted permission to take an examination to determine his fitness to receive a license to practice barbering.

(2) When determining moral character, the board shall consider factors, such as:

(a) If the applicant has been convicted of a crime;

(b) The age of the applicant at the time any criminal conviction was entered;

(c) The length of time that has elapsed since the applicant's last criminal conviction;

(d) The relationship of any crime conviction to the ability of the applicant to properly represent the barbering profession;

(e) Recommendations from barber instructors, licensed barbers, or past or present employers who are not related to the applicant;

(f) Relevant school records; or

(g) Any other factor that is reasonably related to the applicant's ability to fulfill the duties of a professional barber.

Section 2. ***If an applicant is[~~For an applicant~~]*** coming from a state or other board recognizing authority without substantially the same requirements, ***the applicant[~~they~~]*** shall have been a registered barber and worked for three (3) years***, in accordance with KRS 317.450(1)(e)***.[~~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

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GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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 ***of Barbering*** to promulgate ***administrative regulations establishing[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
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GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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. ***The[, and that]*** report shall not be amended without proof ***of[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 available for inspection and shall be included:***

(a) With the student's certification of hours and application for examination, upon completion of the course; or

(b) With the certification of hours:

1. If a student withdraws or is dismissed from school; or

2. Upon the closure of a school[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
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GENERAL GOVERNMENT CABINET
Kentucky Board of Barbering
(As Amended at ARRS, April 14, 2014)

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. ***(1) All fees contained in this administrative regulation shall be:***

(a) Nonrefundable;

(b) Paid by certified check, money order, or cash; and

(c) Received at board headquarters.

(2) If paying in cash, the fee shall be hand delivered at board headquarters.

(3) If paying by certified check or money order, the fee shall be:

(a) Sent through the mail; or

(b) Hand delivered.

Section 2. 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 ***3.[2.]*** Examination fees shall be as follows:
(1) Probationary[~~Apprentice~~] examination: $150;
(2) Barber examination: $150; and
(3) Teacher of barbering examination: $150.

Section ***4.[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 ***5.[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).

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GENERAL GOVERNMENT CABINET
Board of Nursing
(As Amended at ARRS, April 14, 2014)

201 KAR 20:470. Dialysis technician credentialing requirements and training program standards.

RELATES TO: KRS 314.035, ***314.089, 314.091, 314.137, 314.991[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***:***
(a) Initial and ongoing direction, procedural guidance, observation, and evaluation by a registered nurse or physician***; and***
(b) While[, 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 ***completed[***"***]***Application for Dialysis Technician Credential***[***"***]***;
2. Have completed ***a[~~an approved~~]*** dialysis technician training program or an out-of-state dialysis training program pursuant to ***paragraph (b) of this subsection. Program approval shall be based on criteria established in the Dialysis Technician Training Program Guide[~~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 ***submission*** date of the Application ***for Dialysis Technician Credential***;
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 ***submission*** date of the Application ***for Dialysis Technician Credential***;
6. Provide to the board a certified copy of the court record of any misdemeanor or felony conviction from any jurisdiction, except for***:***
a. Traffic-related misdemeanors (other than DUI)***;*** or
b. Misdemeanors older than five (5) years; and
7. Provide to the board a letter of explanation that addresses each conviction ***identified pursuant to subparagraph 6. of this paragraph***.
(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.
2.a. The board or its designee shall evaluate the applicant's training program to determine its comparability with the standards as ***established[~~stated~~]*** in Section 7 of this administrative regulation.
b.[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.
2.[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 ***established[~~set forth~~]*** in the ***[***"***]***Dialysis Technician Training Program Guide***[***"***]***.
3. An applicant shall submit evidence to the board of successful completion of the following sections ***of the Dialysis Technician Training Program Guide***:
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 ***completed [***"***]***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**, pursuant to subsection (1) of this section,** of the Application **for Dialysis Technician Credential**, 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**, based on Section 6(2)(c) of this administrative regulation, if[whether]**:

(a) The Application **for Dialysis Technician Credential** shall be processed with no further action; or

(b) The Application **for Dialysis Technician Credential** 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 **pursuant to[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 **completed ["]**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 **for Renewal of the Dialysis Technician Credential**, 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**. The reinstatement shall be accomplished** by:

(a) Submitting the **completed ["]**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 **submission** date of the Application **for Dialysis Technician Credential**.

(2) If the dialysis technician credential has lapsed for more than one (1) credentialing period, the dialysis technician may reinstate the credential**. The reinstatement shall be accomplished** by:

(a) Completing a **[board-approved]**dialysis technician training program **approved by the board pursuant to the criteria established in the Dialysis Technician Training Program Guide** 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 **completed ["]**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 **submission** date of **the** Application **for Dialysis Technician Credential**; 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 **submission** date of the Application **for Dialysis Technician Credential**.

(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 **for Dialysis Technician Credential pursuant to Section 2(1) of this administrative regulation**, 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 **pursuant to[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**; and[.]**

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 ***established[~~stated~~]*** in Section 5 of this administrative regulation;

(b) Practicing beyond the scope of practice as ***established[~~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) ***Personal*** misuse or misappropriation ***for use of others*** 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 ***applicable requirement of 201 KAR Chapter 20[~~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 ***established[~~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 ***Dialysis Technician[a]*** Credential.

(4) The board shall follow the procedures ***established[~~set out~~]*** in and have the authority ***established[~~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. ***Each dialysis technician training program shall have a registered nurse who holds a current Kentucky license, temporary work permit, or multistate privilege, with at least one (1) year of experience in dialysis care, who[~~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.

(a) The name, title, and credentials identifying the educational and professional qualifications of the program administrator shall be provided to the board.

(b) A change in the program administrator shall be reported to the board within thirty (30) days of the change.

(2) Faculty qualifications.

(a) The dialysis technician training program shall be taught by multidisciplinary faculty with expertise in the subject matter.

(b) 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 ***shall*** 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***:***

1. Clearly defined criteria for evaluating the learner's achievement of program outcomes***; and***

2.[~~.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 ***pursuant to the criteria established in the Dialysis Technician Training Program Guide***.

(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 the faculty member's[~~, 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.

(a) The requirements shall include demonstration of clinical competency and successful completion of a comprehensive, written final examination.

(b) The final examination shall be administered only during the final forty (40) hours of the training program.

(c) 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 ***shall be[~~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)***(a)*** The program shall notify the board in writing within thirty (30) days of a training program closure.

(b) The notification shall include***:***

1. The date of closing***;***

2.[,] A copy of the program trainee roster from the date of the last renewal to the date of closing***;***

3.[,] The location of the program's records as ***established[~~defined~~]*** in subsection (9) of this section***; and***

4.[, ~~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 ***pursuant to the criteria established in the Dialysis Technician Training Program Guide,*** 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 ***a completed*** ***[~~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 ***a completed*** ***[~~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 ***completed*** Application ***for Dialysis Technician Training Program Approval*** 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 ***established[~~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 ***with lapsed approval[~~whose approval has lapsed and~~]*** that seeks to reinstate that approval shall:

(1) File ***a completed*** ***[~~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 ***evaluate compliance with 201 KAR Chapter 20[~~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 ***if applicable***, 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 ***shall[~~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***. A review shall be conducted*** 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 ***that[~~which~~]*** the dialysis technician training program administrator contests.

(b) The board, or ***the board's[~~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 ***Dialysis Technician[~~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 ***continued approval*** 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 ***that[~~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 ***that[~~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)***(a) Holding a credential shall constitute consent by the dialysis technician[~~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***. Notices and orders shall be sent to[~~at~~]*** the mailing address on file with the board.

(b) 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)***(a)*** 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.

(b) Upon learning of any failure to notify the board ***pursuant to this subsection, the board shall[~~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***:***

(a) Is surrendered or terminated under threat of disciplinary action***:***

(b)[~~or~~] Is refused, limited, suspended, or revoked***;[~~,~~]*** or

(c) 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 ***shall[~~may~~]*** require the person to submit to a chemical dependency evaluation or a mental or physical examination by a practitioner it designates.

(a) Holding a credential shall constitute:

1. Consent by the dialysis technician to a chemical dependency evaluation, mental examination, or physical examination if directed in writing by the board. The direction to submit to an evaluation or examination shall contain the basis for the board's concern that the technician is unable to practice safely and effectively; and

2. Waiver of objections to the admissibility of the examining practitioner's testimony or examination reports on the grounds of privileged communication.

(b) The dialysis technician shall bear the cost of chemical dependency evaluation, mental examination, or physical examination ordered by the board.

(c) Upon failure of the dialysis technician to submit to a chemical dependency evaluation, mental examination, or physical examination ordered by the board, unless due to circumstances beyond the person's control, the board shall initiate an action for immediate temporary suspension pursuant to KRS 314.089 or deny an application until the person submits to the required examination.

(d) If a chemical dependency evaluation, mental examination, or physical examination pursuant to this subsection results in a finding that indicates that the dialysis technician is unable to practice with reasonable skill and safety or has abused alcohol or drugs, the dialysis technician shall be subject to disciplinary procedures as established in Section 6 of this administrative regulation[~~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 of 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. ***Due process procedures, including appeal, pertaining to this administrative regulation shall be conducted in accordance with KRS Chapter 13B.***

Section 15. 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.

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,
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GENERAL GOVERNMENT CABINET
Kentucky Board of Physical Therapy
(As Amended at ARRS, April 14, 2014)

201 KAR 22:001. Definitions for 201 KAR Chapter 22.

RELATES TO: KRS 327.010***, 327.050, 327.200***

STATUTORY AUTHORITY: KRS 327.040(11)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 327.040(11) ***authorizes[~~requires~~]*** the Kentucky Board of Physical Therapy to promulgate and enforce reasonable administrative regulations for the effectuation of the purposes of KRS Chapter 327 pertaining to the practice and credentialing of physical therapists and physical therapist assistants. This administrative regulation ***requires[~~sets forth~~]*** the definitions for 201 KAR Chapter 22.

Section 1. Definitions. (1) "Board" is defined by KRS 327.010(3).

(2) "CAPTE" means Commission on Accreditation in Physical Therapy Education.

(3) "Credential" means the license or certificate issued by the board authorizing a person to practice physical therapy.

(4) "Credential holder" means a licensed physical therapist or certified physical therapist assistant who has met all requirements for credentialing in 201 KAR 22:020 and has been credentialed by the board.

(5) "Credentialing" means the process of licensing or certifying an applicant by the board.

(6) "Direct supervision" means:

(a) The physical therapist or physical therapist assistant***[~~shall~~]***:

1. ***Is[~~Be~~]*** immediately available to direct and supervise tasks that are related to direct patient care; and

2. ***Provides[~~Provide~~]*** line of sight direction and supervision the majority of the time per visit for each patient when these tasks are performed; and

(b) Supervision is not provided by ***electronic communication[telecommunications]***.

(7) "Electronic communication" means:

(a) Any transfer of signs, signals, writing, images, sounds, data, information, or intelligence of any nature transmitted by computer or via the internet in whole or in part by a wire, radio, electromagnetic, photo-electronic, or photo-optical system; and

(b) The science and technology of the exchanging of information over any distance by electronic transmission of impulses including activities that involve using electronic communications to store, organize, send, retrieve, or convey information.

(8) "Endorsement" means a method of application which is utilized by an applicant credentialed by another jurisdiction.

(9)[(8)] "Examination" means a board-approved examination that an applicant***[shall]*** successfully ***passes[pass]*** as a requirement for credentialing.

(10)[(9)] "Full time" means employment for forty (40) hours a week.

(11)[(10)] "Inactive status" means a credential that is inactive and the credential holder is not engaged in the practice of physical therapy.

(12)[(11)] "Jurisdiction" means a licensing authority in a state or territory of the U.S.

(13)[(12)] "NPTE" means the National Physical Therapy Examination for physical therapists and physical therapist assistants.

(14)[(13)] "On-site supervision" means immediate physical accessibility within the same building.

(15)[(14)] "Patient" means any person for whom physical therapy***[, as defined in KRS 327.010(1),]*** is provided.

(16)[(15)] ***"Physical therapist" is defined by KRS 327.010(2).***

(17) "Physical therapist assistant" means a skilled health care worker certified by the board who performs physical therapy and related duties as assigned by the supervising physical therapist.

(18)[(17)][(16)] "Physical therapist student" or "physical therapist assistant student" means a person who meets the requirements of KRS 327.050(10)(a).

(19)[(18)][(17)] ***"Physical therapy" is defined by KRS 327.010(1).***

(20) "Physical therapy student services" means services provided by a physical therapist student or physical therapist assistant student, as part of the student's educational program, and are considered ***as*** provided by the supervising physical therapist or physical therapist assistant.

(21)[(19)][(18)] "Reinstatement of a credential" means a renewal of a license that has lapsed.

(22)[(20)][(19)] "Supervising physical therapist" means the physical therapist who is supervising the care of a patient who is being treated by a physical therapist assistant or supportive personnel.

(23)[(21)][(20)] "Supportive personnel" means a person assisting in the provision of direct physical therapy patient care who is not credentialed by the board and is not a physical therapist student or physical therapist assistant student.

(24)[(22)] "Telehealth" is defined by KRS 327.200(3)***[;]***

(25)[(23)] "Telephysical therapy" means ***["]***physical therapy***["as defined by KRS 327.010(1)]*** between the credential holder and the patient who ***are[is]*** not at the same physical location using interactive, secure, synchronous audio***,*** and ***synchronous*** videoconferencing technology.

(26)[(24)][(21)] "Verification" means the process of verifying a lawful credential.

SCOTT D. MAJORS, Executive Director

APPROVED BY AGENCY: January 16, 2014

FILED WITH LRC: February 11, 2014 at 1 p.m.

CONTACT PERSON: Scott D. Majors, Executive Director, Board of Physical Therapy, 312 Whittington Parkway, Suite 102, Louisville, Kentucky 40222, phone (502) 429-7140, fax (502) 429-7142.

GENERAL GOVERNMENT CABINET
Kentucky Board of Physical Therapy
(As Amended at ARRS, April 14, 2014)

201 KAR 22:020. Eligibility and credentialing procedure.

RELATES TO: KRS 164.772, 214.615(1), ***327.010,*** 327.050, 327.060, ***327.075[327.070(2)(f)]***, 327.080

STATUTORY AUTHORITY: KRS 327.040(1), (11), (13)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 327.040(11) authorizes the Board of Physical Therapy to promulgate and enforce reasonable administrative regulations for the effectuation of the purposes of KRS Chapter 327. KRS 327.040(1) requires the board to determine if physical therapist applicants meet the qualifications and standards required by KRS Chapter 327. KRS 327.040(13) authorizes the board to promulgate administrative regulations regarding the qualifications for physical therapist assistants. This administrative regulation establishes the criteria for eligibility, methods, and procedures of qualifying for a credential to practice physical therapy in Kentucky.

Section 1. An application shall be accepted for credentialing as a physical therapist or physical therapist assistant based on successful completion by the applicant of one (1) of the following processes:

(1) Examination;

(2) Endorsement; or

(3) Reinstatement.

Section 2. Examination Candidate. (1) To be eligible for the examination, the applicant for licensure as a physical therapist shall:

(a) Have successfully completed the academic and clinical requirements of a physical therapy program accredited by CAPTE;

(b) Submit certification of completion by the educational administrator of that program;

(c) Have completed an educational course at least two (2) hours in length that has been approved by the Cabinet for Health and Family Services (CHFS) on the transmission, control, treatment, and prevention of human immunodeficiency virus infection and AIDS;

(d) Have successfully completed the Jurisprudence Exam;

(e) Submit a complete Application for Credentialing that includes a photo taken within one (1) year;

(f) Submit the correct, nonrefundable fee as required in 201 KAR 22:135;

(g) If applicable, submit on an Applicant Special Accommodations Request Form a request for a reasonable accommodation in testing due to a documented disability; and

(h) Register for the NPTE examination.

(2) To be eligible for the examination, the applicant for certification as a physical therapist assistant shall:

(a) Have successfully completed the academic and clinical requirements of a physical therapy or physical therapist assistant program accredited by CAPTE; and

(b) Complete the requirements of subsection (1)(b) through (h) of this section.

(3) After three (3) failed attempts in taking the examination, an applicant shall complete a board-approved remediation plan based on identified deficits as provided on the Federation of State Boards of Physical Therapy (FSBPT) Examination Performance Feedback report prior to registering for each subsequent examination.

(4) Effective July 1, 2012, after six (6) failed attempts at either the physical therapist or physical therapist assistant examination, or combination thereof, in any jurisdiction, an applicant shall not be eligible to register for any additional examinations.

Section 3. An applicant for credentialing who is registered for the examination in another jurisdiction shall:

(1) Meet the eligibility requirements of Section 2 of this administrative regulation; and

(2) Register with the FSBPT Score Transfer Service to have results submitted to Kentucky.

Section 4. To be eligible for a temporary permit, the candidate shall:

(1) Meet the qualifications of Section 2 or 3 of this administrative regulation;

(2) Complete a Supervisory Agreement with one (1) or more physical therapists; and

(3) Have not failed either the physical therapist or physical therapist assistant examination in any jurisdiction.

Section 5. Upon issuance of a temporary permit:

(1) The physical therapist or physical therapist assistant applicant shall practice only under the supervision of a physical therapist currently engaged in the practice of physical therapy in Kentucky who:

(a) Has practiced[~~been engaged in the practice of physical therapy~~] in Kentucky for more than one (1) year; and

(b) Has an unrestricted license.

(2) The supervising physical therapist:

(a) Shall be on-site at all times during the practice of the applicant with a temporary permit;

(b) Shall be responsible for the practice of physical therapy by the applicant with a temporary permit;

(c) Shall review, approve, date, and co-sign all physical therapy documentation by the applicant with a temporary permit within twenty-four (24) hours of when the service was provided;

(d) May designate a temporary supervising physical therapist who meets the qualifications of subsection (1)(a) and (b) of this section. The temporary supervising physical therapist shall sign and date written documentation of the acceptance of the responsibility as identified in paragraph (a) through (c) of this subsection; and

(e) Shall notify the board immediately if the supervisory relationship is terminated.

(3) The applicant with a temporary permit shall:

(a) Disclose the applicant's temporary credential status to all patients prior to initiating treatment;

(b) Sign documentation with temporary permit number and designation as defined in 201 KAR 22:053, Section 5(5)(a) or (b); and

(c) Notify the board immediately if the supervisory relationship is terminated.

(4) The temporary permit shall expire the earlier of:

(a) Six (6) months from the date of issuance; or

(b) Notice of exam results by the board.

Section 6. A physical therapist applicant who meets the qualifications for physical therapy licensure by examination may become a special candidate for physical therapist assistant certification by examination.

Section 7. To be eligible for credentialing by endorsement, the applicant shall:

(1) Have successfully completed the academic and clinical requirements of a physical therapy or physical therapist assistant program accredited by CAPTE;

(2) Meet the requirements established in Section 2(1)(b) through (f) of this administrative regulation;

(3) Have successfully completed the NPTE or its equivalent, predecessor examination and register with the FSBPT Score Transfer Service to have results submitted to Kentucky:

(a) A passing score in Kentucky for the person who took the NPTE prior to July 1, 1993, shall be at least equal to the national average raw score minus one and five-tenths (1.5) standard deviation set equal to a converted score of seventy-five (75); or

(b) After July 1, 1993, a passing score shall be the criterion referenced passing point recommended by the FSBPT set equal to a scaled score of 600;

(4) Have an active credential in this profession in another jurisdiction; and

(5) Have verification of credentials showing the credential has never been revoked, suspended, ***placed*** on probation, or is not under disciplinary review in another jurisdiction ***upon[~~at the time of~~]*** application.

Section 8. To be eligible for reinstatement, the applicant shall meet the requirements in 201 KAR 22:040.

Section 9. A credential issued by the board shall be in effect until March 31 of the next odd-numbered year.

Section 10. A foreign-educated physical therapist shall comply with the provisions of 201 KAR 22:070.

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

(a) "Application for Credentialing", December 2011;

(b) "Supervisory Agreement", December 2011; and

(c) "Applicant Special Accommodations Request Form", December 2012.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Board of Physical Therapy, 312 Whittington Parkway Suite 102, Louisville, Kentucky 40222, Monday through Friday, 8 a.m. to 4:30 p.m.

SCOTT D. MAJORS, Executive Director

APPROVED BY AGENCY: January 16, 2014

FILED WITH LRC: February 11, 2014 at 1 p.m.

CONTACT PERSON: Scott D. Majors, Executive Director, Board of Physical Therapy, 312 Whittington Parkway, Suite 102, Louisville, Kentucky 40222, phone (502) 429-7140, fax (502) 429-7142.

GENERAL GOVERNMENT CABINET
Kentucky Board of Licensure and Certification for Dietitians and Nutritionists
(As Amended at ARRS, April 14, 2014)

201 KAR 33:015. Application; approved programs.

RELATES TO: KRS 310.021, 310.031(1), (2)

STATUTORY AUTHORITY: KRS 310.041(1), (2), (6)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 310.041 requires the Kentucky Board of Licensure for Dietitians and Nutritionists to promulgate administrative regulations and to review and approve or reject the qualifications of all applicants for licensure and certification. This administrative regulation establishes the procedure for submitting an application for licensure or certification and establishes requirements for institutions to be approved by the board.

Section 1. Application. (1) An Application for Licensure or Certification shall be submitted to practice dietetics after the requirements established in KRS 310.021 are met.

(2) An Application for Licensure or Certification shall be submitted to practice nutrition after the requirements established in KRS 310.031 are met.

(3) Each Application for Licensure or Certification shall be accompanied by the nonrefundable application fee, established in 201 KAR 33:010.

(4) Each application shall be signed by the applicant.

(5)(a) Each application to practice dietetics shall include***:***

1. A copy of the applicant's current registration card issued by the Commission of Dietetic Registration***; or***

2. A letter indicating successful completion of the registration examination.

(b) ***An Academy of Nutrition and Dietetics[A]*** membership card shall not constitute compliance with paragraph (a)***1.*** of this subsection.

(6) Each application to practice nutrition shall include a certified copy of the applicant's official master's[~~masters~~] transcript.

(7) If the applicant is or was licensed or registered in another jurisdiction, the applicant shall submit a complete Verification of Licensure in Other Jurisdictions form for all jurisdictions where the applicant is currently or has formerly been licensed or registered.

Section 2. Approved Programs. (1) A baccalaureate degree from a college or university approved by the board pursuant to KRS 310.021(3) or 310.031(2)(a) shall be a degree program that is listed as accredited by the Accreditation Council for Education in Nutrition and Dietetics[~~Commission on Accreditation for Dietetics Education~~].

(2) If an applicant's baccalaureate degree is not listed as accredited by the Accreditation Council for Education in Nutrition and Dietetics[~~Commission on Accreditation for Dietetics Education~~], then the applicant shall demonstrate at least forty-five (45) semester hours or sixty-eight (68) quarter hours, as evidenced by a certified copy of an academic transcript, of coursework at the baccalaureate or graduate level in addition to the hours required by KRS 310.031(2)(b). The coursework shall include content specific to each of the following areas:

(a) Communication;
(b) Counseling;
(c) Physical and biological sciences;
(d) Social sciences;
(e) Research;
(f) Food composition;
(g) Nutrient metabolism;
(h) Food systems management;
(i) Nutrition therapy;
(j) Lifecycle nutrition; and
(k) Healthcare systems.

(3) The twelve (12) semester hours of graduate credit required by KRS 310.031(2)(b) shall include only didactic hours of graduate credit specifically related to human nutrition. Examples include:

(a) Food sources of nutrients;
(b) Physiological and chemical processes of digestion, absorption, and metabolism;
(c) Nutrient needs throughout the life cycle;
(d) Nutrition assessment processes;
(e) Pathophysiology of disease states;
(f) Medical nutrition therapy;
(g) Nutrient needs in exercise and fitness; and
(h) Nutrition in health and wellness.

(4) The twelve (12) semester hours of graduate credit required by KRS 310.031(2)(b) shall not include practicums, courses that are primarily obtained from work experiences, independent study, thesis, or dissertation credit hours.

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

(a) "Application for Licensure or Certification", ***April[~~February~~]***, 2014[~~2012~~]; and

(b) "Verification of Licensure in Other Jurisdictions", February, 2014[~~2012~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Division of Occupations and Professions, 911 Leawood Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

AVA EAVES, Board Chair

APPROVED BY AGENCY: January 29, 2014

FILED WITH LRC: February 13, 2014 at 3 p.m.

CONTACT PERSON: Robin Vick, Board Administrator, Kentucky Board of Licensure and Certification for Dietitians and Nutritionists, PO Box 1360, Frankfort, Kentucky 40602, phone 502-564-3296.

GENERAL GOVERNMENT CABINET
Kentucky Board of Licensure and Certification for Dietitians and Nutritionists
(As Amended at ARRS, April 14, 2014)

201 KAR 33:070. Telehealth and telepractice.

RELATES TO: KRS ***310.070,*** 310.200
STATUTORY AUTHORITY: KRS 310.200***(1), (2)***
NECESSITY, FUNCTION, AND CONFORMITY: KRS ***310.200[~~334A.200~~]*** requires the Board of Licensure and Certification for Dietitians and Nutritionists to adopt administrative regulations to further the objectives stated therein. ***This administrative regulation establishes procedures necessary to prevent abuse and fraud through the use of telehealth, prevent fee-splitting through the use of telehealth, and utilize telehealth in the provision of dietitian and nutrition services, and in the provision of continuing education.***

Section 1. Definitions. (1) "Client" means the person receiving the services of the dietitian or nutritionist.

(2) "Educator" means a presenter speaking to a group of individuals on a topic generally without a focus on the specific needs of any particular individual.

(3) "Licensed healthcare ***professional[~~practitioner~~]***" means a medical doctor, registered nurse, ***practical[~~practice~~]*** nurse, nurse practitioner, advanced practice registered nurse, physician's assistant, chiropractor, certified diabetes educator, pharmacist, speech-language pathologist, registered dietitian, certified nutritionist, podiatrist, audiologist, or psychologist licensed in the jurisdiction where ***he or she is[~~they are~~]*** physically located.

(4) "Practitioner" means a licensed dietitian or certified nutritionist.

(5) "Telehealth" is defined by KRS 310.200(3).

(6) "Telepractice" means the practice of dietetics or nutrition as defined by KRS 310.005(2) and provided by using communication technology that is ***two (2) way[~~two-way~~]***, interactive, simultaneous audio and video.

Section 2. Client Requirements. A practitioner-patient relationship shall not commence via telehealth. An initial, in-person meeting for the practitioner and patient who ***will*** prospectively utilize telehealth shall occur in order to ***evaluate if[~~determine whether~~]*** the potential or current client is a candidate to receive services via telehealth. A licensed health care ***professional[~~practitioner~~]*** may represent the practitioner at the initial, in-person meeting. A practitioner who uses telehealth to deliver dietetics or nutrition services shall, at the initial, in-person meeting with the client:

(1) Make ***[~~reasonable~~]*** attempts to verify the identity of the client;

(2) Obtain alternative means of contacting the client other than electronically ***such as by the use of a telephone number or mailing address***;

(3) Provide to the client alternative means of contacting the licensee other than electronically ***such as by the use of a telephone number or mailing address***;

(4) ***Provide contact methods of alternative communication the practitioner shall use for emergency purposes such as an emergency on call telephone number;***

(5) Document if the client has the necessary knowledge and skills to benefit from the type of telepractice provided by the licensee; and

(6)[~~(5)~~] Inform the client in writing ***and document acknowledgement of the risk and limitations of[~~about~~]***:

(a) The ***use of[~~limitations of using~~]*** technology in the provision of telepractice;

(b) ***The*** potential ***breach of[~~risks to~~]*** confidentiality of information***, or inadvertent access of protected health information,*** due to technology in the provision of telepractice;

(c) ***The*** potential***[~~risks of~~]*** disruption ***of technology*** in the use of telepractice;

(d) When and how the practitioner will respond to routine electronic messages;

(e) In what circumstances the practitioner will use alternative communications for emergency purposes;

(f) Who else may have access to client communications with the practitioner;

(g) How communications ***shall[~~can~~]*** be directed to a specific licensee;

(h) How the practitioner stores electronic communications from the client; and

(i) That the practitioner may elect to discontinue the provision

of services through telehealth.

Section 3. Competence, Limits on Practice, Maintenance, and Retention of Records. A practitioner using telehealth to deliver services or who telepractices shall:

(1) Limit the telepractice to the area of competence in which proficiency has been gained through education, training, and experience;

(2) Maintain current competency in telepractice through continuing education, consultation, or other procedures, in conformance with current standards of scientific and professional knowledge;

(3) Document the client's presenting problem, purpose, or diagnosis***, and include which services were provided by telepractice***;

(4) Use secure communications with ***each client[~~clients~~]***, including encrypted text messages, via e-mail or secure Web sites, and not use personal identifying information in non-secure communications; and

(5) Ensure that confidential communications obtained and stored electronically ***shall not[~~cannot~~]*** be recovered and accessed by unauthorized persons when the licensee disposes of electronic equipment and data.

Section 4. Compliance with Federal, State, and Local Law.

(1) A practitioner using telehealth to deliver dietetics or nutrition services shall comply with Section 508 of the Rehabilitation Act, 29 U.S.C. 794(d), to make technology accessible to a client with ***a disability[~~disabilities~~]***.

(2) A person providing dietetic or nutrition services for which an exception to licensure does not apply or who represents himself or herself as a dietitian, licensed dietitian, or certified nutritionist ***pursuant to KRS 310.070 shall be licensed by the board if:***

(a) Services are offered via telehealth; and

(b) These services are provided or the representation is made to a person when he or she is physically located in Kentucky[~~via telehealth to a person who, at the time the services are provided or the representation is made, is physically located in Kentucky shall be licensed by the board~~].

(3) A person providing dietetic or nutrition services for which an exception to licensure does not apply or who represents himself or herself as a dietitian, licensed dietitian, or certified nutritionist ***pursuant to KRS 310.070 shall be licensed by the board if:***

(a) Services are offered via telehealth***; and***

(b) These services are provided or the representation is made from a physical location in Kentucky***[~~shall be licensed by the board~~]***. This person may be subject to licensure requirements in other states where the services are received by the client.

(4) No provision of this administrative regulation shall restrict the ability of educators to present on topics related to dietetics and nutrition ***pursuant to KRS 310.070(2)(d)***.

Section 5. Representation of Services and Code of Conduct. A licensee using telehealth to deliver services or who telepractices shall not:

(1) Engage in false, misleading, or deceptive advertising of telepractice; ***or[~~and~~]***

(2) Split fees.

AVA EAVES, Board Chair

APPROVED BY AGENCY: January 29, 2014

FILED WITH LRC: February 13, 2014 at 3 p.m.

CONTACT PERSON: Robin Vick, Board Administrator, Kentucky Board of Licensure and Certification for Dietitians and Nutritionists, PO Box 1360, Frankfort, Kentucky 40602 phone 502-564-3296.

TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(As Amended at ARRS, April 14, 2014)

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 ***Commercial*** 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 ***Commercial*** 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 ***that[~~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)***1.*** Fifty (50) yards of the outlet or inlet of an overflow lake; or

2.[(b)] Fifty (50) yards of the mouth of a stream except the mouth of the Ohio River; and

(b)[(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***, there shall be***:

(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 ***2014 amendment*** 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 ***2014 amendment*** 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 ***2014 amendment*** 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.~~] ***Harvester[~~Roe-bearing Fish Harvester's~~]*** Permit. (1) In order to retain his or her permit privilege, a ***harvester[~~Roe-bearing Fish~~]*** permit holder shall submit to the department the following by September 15:

(a) A completed Application for ***Commercial*** Roe-bearing Fish Harvester's Permit; and

(b) The permit fee as established in 301 KAR 3:022.

(2) A mailed Application ***for Commercial Roe-bearing Fish Harvester's Permit*** 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 ***harvester[~~Roe-bearing Fish Harvester's~~]*** permits available each year shall be 101.

(6) The maximum number of nonresident ***harvester[~~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 ***14[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 ***Application for Commercial*** Roe-bearing Fish ***Harvester's[~~Harvester~~]*** Permit***[~~Application~~]***; and

(b) The appropriate permit fee as established in 301 KAR 3:022.

(3) A mailed Application ***for Commercial Roe-bearing Fish Harvester's Permit*** 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 ***Applications for Commercial Roe-bearing Fish Harvester's Permits****[harvester permit applications]* than the number of available ***harvester*** permits, then completed Applications ***for Commercial Roe-bearing Fish Harvester's Permits*** 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 ***for Commercial Roe-bearing Fish Harvester's Permits*** received on a day after September 15 exceeds the number of ***harvester*** 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 ***14****[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 ***9****[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 ***established****[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 ***established****[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 ***established****[specified]* in 301 KAR 1:140.

(3) A harvester or buyer permit holder shall not possess:

(a) Unprocessed Paddlefish roe after June 5;[or]

(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****[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 ***Transaction*** 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 ***4(2)[3(2)]*** and ***(3)[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
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.

TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(As Amended at ARRS, April 14, 2014)

301 KAR 2:049. Small game and furbearer hunting and trapping on public and other federally owned areas.

RELATES TO: KRS 150.010, 150.092, 150.170, 150.370, 150.399, 150.400, 150.410, 150.990, 150.995
STATUTORY AUTHORITY: KRS 150.025(1), 150.620
NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish open seasons for the taking of wildlife, to regulate bag limits and methods of take, and to make these requirements apply statewide or to a limited area. 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 exceptions to statewide small game and furbearer regulations on public areas.

Section 1. Definitions. (1) "Adult" means a person who is at least eighteen (18) years of age.

(2) "Upland bird" means a grouse or northern bobwhite.

(3) "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.

(4) "Youth" means a person under the age of sixteen (16) by the date of the hunt.

Section 2. This administrative regulation shall establish exceptions to the statewide requirements established in 301 KAR 2:122, 2:251, and 3:010.

Section 3. General Requirements on a Wildlife Management Area or Outdoor Recreation Area.[~~owned or managed by the department:~~]

(1) ***Except as established in subsection (2) of this section,*** a person hunting any species during daylight hours, and any person accompanying that hunter, shall comply with[~~wear~~] hunter orange requirements[~~clothing if a firearm is allowed for deer hunting,~~] as established in 301 KAR 2:132, 2:172, and 2:300.[~~;~~]

(2) The hunter orange clothing requirement in subsection (1) of this section shall not apply to a person hunting waterfowl.[~~:~~

~~(a) Waterfowl; or~~

~~(b) Raccoon or opossum at night;~~]

(3) There shall be a free youth small game hunting week for seven (7) consecutive days beginning on the Saturday after Christmas, in which a youth may take small game without a hunting license.[~~; and~~]

(4) There shall be a free youth trapping week for seven (7) consecutive days beginning on the Saturday after Christmas, in which a youth may trap without a trapping license.

Section 4. Exceptions on Wildlife Management Areas and

Outdoor Recreation[~~Specific Public~~] Areas. (1) Barren River Wildlife Management Area.

(a) The WMA shall be considered to be entirely within the Eastern Zone, as established in 301 KAR 2:122.

(b) Northern bobwhite and rabbit seasons shall be closed after December 31.

(c) On the Peninsula Unit, including Narrows, Goose and Grass Islands, a person shall not hunt with a breech-loading firearm.

(2) Beaver Creek WMA, including private inholdings.

(a) Grouse season shall be open from October 1 through December 31.

(b) Northern bobwhite and rabbit seasons shall be closed after December 31.

(c) A person shall hunt coyotes during daylight hours only.

(3)[~~Big South Fork National River and Recreation Area, McCreary County.~~

~~(a) Grouse season shall be open from October 1 through December 31.~~

~~(b) Northern bobwhite and rabbit seasons shall be closed after December 31.~~

~~(4)~~] Cane Creek WMA, including private inholdings.

(a) Grouse season shall be open from October 1 through December 31.

(b) Northern bobwhite and rabbit seasons shall be closed after December 31.

(c) A person shall hunt coyotes during daylight hours only.

(4)[~~(5)~~] Cedar Creek Lake WMA.

(a) Rabbit season shall be closed after December 31.

(b) With the exception of the statewide squirrel season,[~~shall coincide with the statewide season.~~

~~(c)~~] the area shall be closed to all other small game and furbearer hunting.

(5)[~~(6)~~] Clay WMA.

(a) The area shall be closed for four (4) consecutive days beginning on the first Friday in December to all hunting except archery deer hunting and the pheasant quota hunt established in Section 5 of this administrative regulation.

(b) Rabbit season shall be closed after December 31.

(c) Grouse and northern bobwhite hunting shall be restricted to quota hunt dates established in Section 5 of this administrative regulation.

(d) Pheasant may be taken beginning on the Tuesday following the pheasant quota hunt through December 31.

1. Any person with a valid hunting license may take a pheasant.

2. The daily limit per hunter shall be three (3) birds of either sex.

(e) Quota fox hunting field trials.

1. There shall be a maximum of two (2) four (4) day events per calendar year.

2. Each event shall be limited to 250 participants.

3. The area shall be closed to nonparticipants.

4. A participant shall:

a. Wear a laminated identification badge issued by the department during the event; and[~~.~~]

b. Return the laminated badge at the close of the event.

(6)[~~(7)~~] Curtis Gates Lloyd WMA.

(a) Northern bobwhite and rabbit seasons shall be closed after December 31.

(b) A person shall not allow a dog to be unleashed from April 1 until the third Saturday in August except if squirrel hunting.

(7)[~~(8)~~] Dix River WMA.

(a) Northern bobwhite and rabbit seasons shall be closed after December 31.

(b) Grouse season shall be open from October 1 through December 31.

(8)[~~(9)~~] Fleming WMA.

(a) Northern bobwhite and rabbit seasons shall be closed after December 31.

(b) Grouse season shall be open from October 1 through December 31.

(9)[~~(10)~~] Green River Lake WMA.

(a) The area shall be closed to all hunting for four (4) consecutive days beginning on the third Friday in November except for archery deer hunting and the pheasant quota hunt established in Section 5 of this administrative regulation.

(b) Northern bobwhite and rabbit seasons shall be closed after December 31.

(c) Pheasant.

1. Beginning on the Tuesday following the pheasant quota hunt through December 31, any person with a valid hunting license may take a pheasant.

2. The daily limit per hunter shall be three (3) birds of either sex.

(d) The area shall be closed to grouse hunting and trapping.

(10)[~~(11)~~] Higginson-Henry WMA. Northern bobwhite and rabbit seasons shall be closed after December 31.

(11)[~~(12)~~] Kleber WMA. Northern bobwhite and rabbit seasons shall be closed after December 31.

(12)[~~(13)~~] Lake Cumberland WMA.

(a) Grouse season shall be open from October 1 through December 31.

(b) Northern bobwhite and rabbit seasons shall be closed after December 31.

(13)[~~(14)~~] Mill Creek WMA.

(a) Northern bobwhite and rabbit seasons shall be closed after December 31.

(b) A person shall hunt coyotes during daylight hours only.

(14)[~~(15)~~] Miller-Welch Central Kentucky WMA.

(a) Small game and furbearer hunting seasons shall be closed, except that squirrel season shall be open.

(b) A person shall not allow a dog to be unleashed:

1. From April 1 until the third Saturday in August; or[~~.~~]

2. On a Monday, Wednesday, or Friday during the remainder of the year, except:

a. If a person is hunting squirrels during an open season; or

b. If a person is participating in an authorized field trial.

(15)[~~(16)~~] Mullins WMA. Northern bobwhite and rabbit seasons shall be closed after December 31.

(16)[~~(17)~~] Nolin Lake WMA. Northern bobwhite and rabbit seasons shall be closed after December 31.

(17)[~~(18)~~] Otter Creek Outdoor Recreation Area.

(a) Except as authorized by the department, a person shall not enter the area during a deer quota hunt without a valid quota hunt confirmation number.

(b) Northern bobwhite season shall be closed.

(c) Rabbit hunting season shall be from December 1 through December 31.

(d) Trapping season shall be from January 1 through the last day in February.

(e) A person who traps on the area shall:

1. First obtain prior authorization from the area manager; and

2. Only trap in department designated areas.

(f) Except during deer quota hunts, a person shall not use the following to take furbearers:

1. A rifle;

2. Ball ammunition; or

3. Slug ammunition.

(g) A person shall not use a rimfire gun to take small game, except during a deer quota hunt.

(18)[~~(19)~~] Paul Van Booven WMA. The area shall be closed to vehicle access from one (1) hour after sunset until one (1) hour before sunrise.

(19)[~~(20)~~] Peabody WMA.

(a) Northern bobwhite hunting on the Sinclair Unit shall:

1. Have shooting hours between 7:30 a.m. and 3:00 p.m.; and

2. Be closed on Sunday.

(b) A northern bobwhite hunter on the Sinclair Unit shall:

1. Check in and check out at the Peabody WMA office; and

2. Visibly display a hunting log on the dashboard of the hunter's vehicle.

(20)[~~(21)~~] Pennyrile Forest WMA.

(a) Grouse season shall be open from December 1 through December 31.

(b) The daily limit shall be two (2).

(21)[(~~22~~)] Pioneer Weapons WMA.

(a) A person shall not hunt with a breech-loading firearm.

(b) A person shall hunt coyotes during daylight hours only.

(22)[(~~23~~)] Robinson Forest WMA.

(a) Hunting shall not be permitted on the Main Block.

(b) The remainder of the WMA shall be open under statewide requirements.

(c) A person shall hunt coyotes during daylight hours only.

(23)[(~~24~~)] Taylorsville Lake WMA. Northern bobwhite and rabbit seasons shall be closed after December 31.

(24) [(~~25~~)] Tradewater WMA.

(a) Grouse season shall be open from December 1 through December 31.

(b) The daily limit shall be two (2) ***grouse***.

(25)[(~~26~~)] West Kentucky WMA.

(a) A person shall check in daily at a designated check station prior to using an "A" tract.

(b) Northern bobwhite and rabbit seasons shall be closed after December 31 on Tracts 2, 3, 6, and 7.

(c) Northern bobwhite and rabbit seasons shall be open on Tracts 1, 4, 5, and "A" beginning one-half (1/2) hour before sunrise until 1:00 p.m. local time from January 1 through January 10, except if harvest limits are reached prior to January 10.[;]

1. A hunter shall report harvest numbers and total hours hunted to the area supervisor on a daily basis.

2. If a tract is closed prior to January 10, a sign indicating closure shall be posted at the hunter check station at least twenty-four (24) hours prior to the closure.

(d) A person shall not:

1. Use a rifle, ball, or slug ammunition;

2. Operate a vehicle on Tract 6 from February 1 through April 16; or

3. Allow a dog to be unleashed from April 1 until the third Saturday in August, except while squirrel hunting.

(26)[(~~27~~)] Yellowbank WMA.

(a) Northern bobwhite and rabbit seasons shall be closed after December 31.

(b) Pheasant may be taken beginning on the Tuesday following the pheasant quota hunt through December 31.

(c) A person shall:

1. Possess a valid hunting license to take pheasant, unless exempt pursuant to KRS 150.170; and

2. Not take more than three (3) pheasants of either sex.

Section 5. Pheasant Quota Hunts. (1) There shall be a pheasant quota hunt on:

(a) Green River Wildlife Management Area for three (3) consecutive days beginning the third Friday in November;[.]

(b) Clay Wildlife Management Area for three (3) consecutive days beginning the first Friday in December; and[.]

(c) Yellowbank Wildlife Management Area for three (3) consecutive days beginning on the second Friday in December.

(2) There shall be a one (1) day clean-up hunt immediately following each of the hunts for pheasant quota hunters drawn for that particular WMA.

(3) Hunt hours for each day shall be from 9:00 a.m. to 4:00 p.m.:

(a) Eastern time for the Green River Wildlife Management Area and Clay Wildlife Management Area hunts; and

(b) Central time for the Yellowbank Wildlife Management Area hunt.

(4) During a quota hunt or clean-up hunt, a person shall wear orange clothing as ***established[~~specified~~]*** in 301 KAR 2:172.

(5) The daily bag limit per hunter shall be two (2) birds of either sex, except there shall be a daily bag limit of three (3) birds of either sex during the one (1) day clean-up hunt.

(6) Pheasant quota hunt procedures.

(a) A person selected for a pheasant quota hunt may hunt on the one (1) day clean-up hunt for that area.

(b) A person applying for a pheasant quota hunt shall:

1. Not apply more than one (1) time for each hunt and shall not be drawn for more than one (1) hunt; and

2. Not apply as a group of more than five (5) people.

(c) A person who is drawn to hunt shall pay the pheasant quota hunt permit fee established in 301 KAR 3:022[,] prior to the hunt.

Section 6. Northern Bobwhite and Upland Bird Quota Hunts. (1) There shall be one (1) day northern bobwhite quota hunts on one (1) tract of Peabody WMA on the following days:

(a) The fourth Saturday in November, which shall only be a youth-mentor hunt;

(b) The Tuesday following the fourth Saturday in November;

(c) The Tuesday following the third Saturday in December;

(d) The first Saturday in January;

(e) The second Saturday in January; and

(f) The Tuesday following the third Saturday in January.

(2) There shall be one (1) day upland bird quota hunts on Clay WMA on the following days:

(a) On the Wednesday following the first Saturday in November;

(b) The third Sunday in November;

(c) The second Sunday in December; and

(d) The third Tuesday in December.

(3) A person participating in a quota hunt shall:

(a) Only hunt from one-half (1/2) hour before sunrise to 2:00 p.m.;

(b) Wear hunter orange clothing pursuant to 301 KAR 2:172; and

(c) Not take more than four (4) northern bobwhite on a daily basis.

(4) A person who participates in an upland bird quota hunt:

(a) Shall not take more than four (4) grouse daily; and

(b) May take woodcock***. Woodcock shall be taken*** pursuant to the requirements established in 301 KAR 2:225.

(5) A person applying for a northern bobwhite or upland bird quota hunt shall:

(a) Not apply more than one (1) time for each hunt and shall not be drawn for more than one (1) hunt; and

(b) Not apply as a group of more than three (3) people.

(6) A person selected for a quota hunt shall only hunt the species identified on the permit.

Section 7. General Quota Hunt Requirements. (1) A person applying for a pheasant, northern bobwhite, or upland bird quota hunt shall:

(a) Call the toll-free number listed in the current Fall Hunting and Trapping Guide from a touch tone phone between September 1 and September 30;

(b) Enter each applicant's Social Security number;

(c) Indicate a choice of days to hunt; and

(d) Pay a three (3) dollar application fee for each applicant prior to the drawing by:

1. Check;

2. Money order;

3. Visa; or

4. MasterCard.

(2) A person, prior to participating in a quota hunt, shall be required to show:

(a) A department-issued quota hunt permit;

(b) A valid Kentucky hunting license or proof of exemption; and

(c) A hunter education card, if required.

(3) A person or group participating in a northern bobwhite or upland bird quota hunt shall submit a hunting log within seven (7) days after the hunt.

(4) A youth-mentor quota hunt party shall have a minimum of one (1) youth as a member of the party.

(5) A person shall comply with all quota hunt requirements or be ineligible to apply for any other quota hunt during the following year, except for an elk quota hunt.

(6) A youth shall only apply as part of a party that has at least one (1) adult.

(7) The department 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 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.

(9) A random selection of hunters with preference points shall be made for each year's quota hunts before those without preference points are chosen.

(10) A person shall forfeit all accumulated points if, in a given year, the person does not apply for the hunt in which points were earned.

Section 8. Dog Training Areas on Wildlife Management Areas.

(1) A group or club may request that a dedicated dog training area be authorized by the department on a specific WMA.

(2) The department shall authorize a dog training area if:

(a) The department approves a suitable location for the dog training area; and

(b) A signed memorandum of understanding is entered into with the club or group.

(3) The [~~following~~] conditions established in this subsection shall apply for each dog training area on a WMA.[~~:~~]

(a) All northern bobwhite quail to be used in training shall be banded with aluminum leg bands and individually placed in the dog training area.[~~;~~]

(b) Dog training areas shall remain open to all other legal WMA uses.[~~;~~]

(c) A person shall comply with all dog training area requirements pursuant to 301 KAR 2:041, unless otherwise stated in the memorandum of understanding.[~~;~~]

(d) Unleashed dogs shall be allowed within the boundaries of the dog training area year-round, except for the following days:

1. May 15 through August 15;

2. Youth statewide turkey season; and

3. Statewide turkey season.[~~;~~]

(e) Released northern bobwhite quail with aluminum leg bands, chukars, pheasants, or pigeons may be harvested on legal dog training days.[~~; and~~]

(f) Immediately prior to dog training, a person shall:

1. Walk and examine the entire dog training area to ensure that no wild northern bobwhite quail are present; and

2. Then place released birds in the training area.

Section 9. General Requirements on Federally Owned Areas.

(1) Season dates, bag limits and other requirements of 301 KAR 2:251, 2:049, and 2:050 shall apply ***except as otherwise established[~~unless specified otherwise~~]*** in this administrative regulation.

(2) Hunter orange requirements ***established[~~referenced~~]*** in Section 3 of this administrative regulation shall apply to ***a[~~any~~]*** person hunting or trapping on federal areas referenced in this section.

(3) A person shall:

(a) Obtain permission, in the form of area permits, before hunting;

(b) Not hunt except on assigned dates and in assigned areas; and

(c) Comply with any requirements established by the agency controlling the area.

Section 10. Exceptions on Specific Federally Owned Areas. (1) If hunting is not prohibited by other area priorities, Fort Campbell, Fort Knox, Land Between the Lakes National Recreation Area, Bluegrass Army Depot, and Reelfoot National Wildlife Refuge may allow hunting ***if in compliance with[~~as established in~~]*** 301 KAR 2:122 and 2:251***[~~, and~~]*** for:

(a) Squirrels, from June 1 through June 14;

(b) Quail and rabbit, no earlier than November 1 nor later than the last day of February;

(c) Furbearers, no earlier than October 1 nor later than the last day of February;

(d) Frogs, year round; or

(e) Crows, for a maximum of 124 days between September 1 and the last day of February.

(2) A person shall hunt coyotes during daylight hours only on lands managed by:

(a) Daniel Boone National Forest;

(b) George Washington and Jefferson National Forests;

(c) Land Between the Lakes National Recreation Area;

(d) Clarks River National Wildlife Refuge; and

(e) Reelfoot National Wildlife Refuge.

(3) Fort Knox shall not allow more than thirty (30) days of grouse hunting between October 1 and the last day of February.

(4) On Land Between the Lakes National Recreation Area, a person hunting the species listed in this administrative regulation shall not use:

(a) Crossbows;

(b) Shotgun slugs or shot larger than BB; or

(c) Center-fire rifles or center-fire handguns, except during designated groundhog or coyote hunts.

(5) Big South Fork National River and Recreation Area.

(a) Grouse season shall be open from October 1 through December 31.

(b) Northern bobwhite and rabbit seasons shall be closed after December 31.

(c) A person hunting coyotes shall comply with any federal requirements established by the National Park Service.

MATT SAWYERS, Acting Commissioner
ROBERT H. STEWART, Secretary
APPROVED BY AGENCY: February 11, 2014
FILED WITH LRC: February 13, 2014 at 3 p.m.
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TOURISM, ARTS AND HERITAGE CABINET
Kentucky Department of Fish and Wildlife Resources
(As Amended at ARRS, April 14, 2014)

301 KAR 2:251. Hunting and trapping seasons and limits for furbearers.

RELATES TO: KRS 150.170, 150.180, 150.370, 150.399,[~~150.400,~~] 150.415, 150.416, 150.990, 150.995

STATUTORY AUTHORITY: KRS 150.025(1), 150.175(7), (9), 150.360[~~(6)~~], 150.400, 150.410

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish open seasons for the taking of wildlife, to regulate bag limits and methods of take, and to make these requirements apply to a limited area. KRS 150.175(7), (9) authorizes the department to issue licenses, permits, and tags for hunting and trapping. KRS 150.410 authorizes the department to regulate trap tags, trap visitation, and trap placement to protect domestic animals. KRS 150.360 ***requires[~~places~~]*** restrictions on the taking of wildlife and[~~(6)~~] authorizes the department to promulgate administrative regulations establishing the requirements for hunting coyotes at night[~~with or without the use of lights or other means designed to make wildlife visible at night~~]. This administrative regulation establishes seasons, bag limits, and legal methods for hunting and trapping furbearers.

Section 1. Definitions. (1) "Body-gripping trap" means a commercially manufactured spring-loaded trap designed to kill the animal upon capture.

(2) "Dry land set" means a trap that is not set to submerge an animal in water upon capture.

(3) "Foothold trap" means a commercially manufactured spring-loaded trap with smooth, metallic or rubber soft-catch jaws that close upon an animal's foot.

(4) "Furbearer" means mink, muskrat, beaver, raccoon, opossum, gray fox, red fox, least weasel, long-tailed weasel, river otter, bobcat, coyote, or striped skunk.

(5) "Hunter" means a person hunting furbearers with gun, gun and dog, bow and arrow, dog, or by falconry.

(6) "Otter Zone 1" means the following counties: Anderson,

Ballard, Bath, Boone, Bourbon, Bracken, Breckinridge, Bullitt, Caldwell, Calloway, Campbell, Carlisle, Carroll, Christian, Crittenden, Daviess, Fayette, Fleming, Franklin, Fulton, Gallatin, Grant, Graves, Grayson, Hancock, Hardin, Harrison, Henderson, Henry, Hickman, Hopkins, Jefferson, Kenton, Larue, Livingston, Lyon, Marshall, Mason, McCracken, McLean, Meade, Muhlenberg, Nelson, Nicholas, Ohio, Oldham, Owen, Pendleton, Robertson, Rowan, Scott, Shelby, Spencer, Trigg, Trimble, Union, Webster, and Woodford.

(7) "Otter Zone 2" means all Kentucky counties not included in subsection (6) of this section.

(8) "Snare" means a wire, cable, or string with a knot, loop, or a single piece closing device, the deployment of which ***is or is not[may be]*** spring-assisted, but ***any spring-assisted device is*** not for the purpose of applying tension to the closing device[~~which is not power or spring assisted~~].

(9) "Squaller" means a hand-operated, mouth-operated, or electronic call capable of mimicking the vocalizations of furbearers.

(10) "Trap" means a body-gripping trap, box trap, deadfall, foothold trap, snare, or wire cage trap used to catch furbearers.

(11) "Water set" means a trap set to submerge an animal in water upon capture.

(12) "Youth" means a person who has not reached sixteen (16) years of age.

Section 2.[~~Harvest Methods for Furbearers. Unless specified in Section 3(9) of this administrative regulation, a person shall only use the following to take furbearers:~~

~~(1) Centerfire gun;~~

~~(2) Rimfire gun;~~

~~(3) Shotgun;~~

~~(4) Bow and arrow;~~

~~(5) Crossbow; or~~

~~(6) An air gun using pellets at least.22 caliber in size.~~

~~Section 3.~~] Hunting Requirements. (1) Unless exempted by KRS 150.170, a person shall carry proof of purchase of a valid hunting license while hunting furbearers.

(2) Unless established in subsection (10) of this section, a hunter shall only use the weapons established in paragraphs (a) through (f) of this subsection to take furbearers:

(a) Centerfire gun;

(b) Rimfire gun;

(c) Shotgun;

(d) Bow and arrow;

(e) Crossbow; or

(f) An air gun using pellets at least .22 caliber in size.

(3) Furbearers may be taken during daylight hours only, except for the following, which may also be taken after daylight hours:

(a) Coyote;

(b) Opossum; or

(c) Raccoon.

(4)[~~(3)~~] A person shall not take a raccoon or opossum during daylight hours during the modern gun deer season, as established in 301 KAR 2:172.

(5)[~~(4)~~] A hunter in a boat shall not use a light ***in conjunction with taking[~~to take~~]*** a raccoon or opossum.

(6)[~~(5)~~] A person shall not use the following while chasing a raccoon or opossum from noon on March 1 through September 30;

(a) A firearm;

(b) Slingshot;

(c) Tree climber; or

(d) Any device to kill, injure, or force a raccoon or opossum from a tree or den.

(7)[~~(6)~~] A person may use a squaller year-round.

(8)[~~(7)~~] There shall not be a closed season on:

(a) Chasing red and gray foxes during daylight hours for sport and not to kill; ***or[~~and~~]***

(b) Chasing raccoons or opossums for sport and not to kill.

(9)[~~(8)~~] A hunter may use a hand or mouth-operated call, electronic call, or any other attracting device during a furbearer hunting season.

(10)[~~(9)~~] A person may take a coyote after daylight hours, with the following restrictions:

(a) A person shall not use artificial light or other means designed to make wildlife visible at night from June 1 through January 31;

(b) Any artificial light or other means designed to make wildlife visible at night shall not be connected to or cast from a mechanized vehicle;

(c) A person shall not use any weapon other than a shotgun; and

(d) A person shall not use a shell with a single projectile.

Section 3.[~~4.~~] Trapping Methods and Requirements. (1) Unless exempted by KRS 150.170, a person shall carry proof of purchase of a valid trapping license while trapping furbearers.

(2) A person who is trapping ***with a dry land set[~~on dry land~~]*** shall not:

(a) Set traps closer than ten (10) feet apart; or

(b) Use any trap except for the following:

1. Deadfall;

2. Wire cage or box trap;

3. Foothold trap with a maximum inside jaw spread of six (6) inches measured perpendicular to the hinges;

4. Body-gripping trap with a maximum inside jaw spread of seven and one-half (7.5) inches measured parallel with the trigger; or

5. A snare.

(3) There shall be no restrictions on the size or type of trap used as a water set.

(4) A trap shall not be set in a trail or path commonly used by a human or a domestic animal.

(5) A trapper may use lights from a boat or a vehicle ***in conjunction with trapping furbearers***.

Section 4.[~~5.~~] Trap Tags. (1) Each trap shall have a metal tag attached to it that clearly shows one (1) of the following:

(a) The name and address of the person setting, using, or maintaining the trap; or

(b) A wildlife identification number issued by the department and the 1-800-25ALERT department hotline phone number.

(2) A person applying for a wildlife identification number shall apply by:

(a) ***Completing the Wildlife Identification Number for Trap Tags – Application available on[~~Accessing~~]*** the department's Web site at www.fw.ky.gov; or

(b) Calling the department's information center at 1-800-858-1549.

(3) The following information shall be required for a person to apply for a wildlife identification number:

(a) Name;

(b) Current home address;

(c) Social Security number;

(d) Current phone number;

(e) Date of birth; and

(f) Driver's license number, if available.

(4) A person shall:

(a) Not use a trap tag that has an inaccurate or outdated address;

(b) Not use a trap tag that has a wildlife identification number that corresponds to an inaccurate or outdated address or phone number; and

(c) Contact the department to provide updated address and phone number.

(5) A wildlife identification number shall be[~~is~~] valid for the life of the holder.

Section 5.[~~6.~~] Hunting Season Dates. Except as ***established[~~specified~~]*** in 301 KAR 2:049***[~~or 301 KAR 2:125~~]***, a person shall not take the following wildlife except during the dates ***established[~~specified~~]*** in this section:

(1) Bobcat: from one-half hour before sunrise[~~noon~~] on the fourth Saturday in November through the last day of February;[.]

(2) Coyote: year round;[.]

(3) Raccoon and Opossum: October 1 through the last day of February;[.]

(4) All other furbearers ***except as established in subsection (5) of this section***: from one-half hour before sunrise[~~noon~~] on the third day of the modern gun deer season through the last day of February; or[~~.~~]

(5) Furbearers taken by falconry: September 1 through March 30.

Section 6.[~~7.~~] Trapping Season Dates. Except as ***established[~~specified~~]*** in 301 KAR 2:049***[~~or 301 KAR 2:125~~]***, a person shall not take furbearers except from ***one-half hour before sunrise[~~noon~~]*** on the third day of the modern gun deer season through the last day of February.

Section 7.[~~8.~~] License-Exempt Season for Youth. For seven (7) consecutive days beginning on the Saturday after Christmas, a youth may hunt or trap furbearers without a license, but all other statewide requirements shall apply.

Section 8.[~~9.~~] Bag Limits. There shall not be a bag limit on furbearers except as established in this section.[~~:~~]

(1) A person shall not take more than five (5) bobcats per season, no more than three (3) of which shall be taken with a gun.[~~;~~]

(2) A person shall not take more than ten (10) river otters per season in Otter Zone 1.[~~;~~]

(3) A person shall not take more than six (6) river otters per season in Otter Zone 2.[~~;~~]

(4) The total river otter bag limit per season shall be ten (10) per person, only six (6) of which can be taken from Otter Zone 2.[~~; and~~]

(5) A falconer hunting within the falconry season, but outside the dates specified in Section 5(3)[~~6(3)~~] and (4) of this administrative regulation, shall not take more than two (2) of any furbearer per day.

Section 9.[~~10.~~] Harvest Recording. (1) Immediately after taking a river otter or bobcat, and before moving the carcass, a person shall record in writing the following information:

(a) The species;

(b) The date;

(c) The county where taken; and

(d) The sex of the animal.

(2) The information listed in subsection (1) of this section shall be recorded on one (1) of the following:

(a) The hunter's log section on the reverse side of a license or permit;

(b) The hunter's log section in the current hunting and trapping guide;

(c) A hunter's log available from any KDSS agent; or

(d) An index card or similar card.

(3) A person shall retain and possess the completed hunter's log while hunting or trapping during the current season.

Section 10.[~~11.~~] Checking a River Otter or Bobcat. (1) A person who takes a river otter or bobcat shall:

(a) Check each animal by calling the toll free number listed in the current hunting and trapping guide on the day the river otter or bobcat is harvested;

(b) Provide the information requested by the automated check-in system; and

(c) Write the confirmation number provided by the automated check-in system on the hunter's log ***established[~~described~~]*** in Section 9[~~10~~] of this administrative regulation.

(2) A person who intends to sell the raw fur of a river otter or bobcat to a licensed fur processor, fur buyer, or taxidermist or wishing to export a river otter or bobcat pelt outside the United States shall:

(a) Contact the department and request a Convention on International Trade of Endangered Species of Flora and Fauna (CITES) tag by providing:

1. A valid confirmation number as ***established[~~described~~]*** in subsection (1) of this section; and

2. A street address where the tag is to be mailed; or

(b) Access the department's Web site at www.fw.ky.gov and complete and submit the CITES tag request form to the department.

(3) A person who intends to transfer to another person a river otter or bobcat that does not have an attached CITES tag shall attach to the carcass a handmade tag that contains the following:

(a) The confirmation number;

(b) The hunter or trapper's name; and

(c) The hunter or trapper's phone number.

(4) A person shall not provide false information ***while[~~when~~]***:

(a) Completing the hunter's log;

(b) Checking a river otter or bobcat; or

(c) Creating a handmade carcass tag.

(5) A CITES tag shall be attached to the raw fur, pelt, or unskinned carcass per the instructions provided by the department and remain with the pelt until it is processed or exported outside the United States.

(6) Possession of an unused CITES tag ***that is issued by the department shall be[~~is~~]*** prohibited***[~~unless authorized by the department~~]***.

Section 11.[~~12.~~] Transporting and Processing a River Otter or Bobcat. (1) A person shall not sell the raw fur of a river otter or bobcat except to a licensed:

(a) Fur buyer;

(b) Fur processor; or

(c) Taxidermist.

(2) A taxidermist, fur buyer, or fur processor shall:

(a) Not accept a river otter or bobcat carcass or any part of a river otter or bobcat without a proper carcass tag or CITES tag ***established[~~described~~]*** in Section 10[~~11~~] of this administrative regulation; and

(b) Keep the following information from a hunter or trapper:

1. Name;

2. Address;

3. Confirmation number or CITES tag number; and

4. Date received for each river otter or bobcat.

Section 12. Incorporation by Reference. (1) "Wildlife Identification Number for Trap Tags – Application", April 2014, is incorporated by reference.

(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: February 11, 2014

FILED WITH LRC: February 13, 2014 at 3 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.

JUSTICE AND PUBLIC SAFETY CABINET
Department of Corrections
(As Amended at ARRS, April 14, 2014)

501 KAR 6:170. Green River Correctional Complex.

RELATES TO: KRS Chapters 196, 197, 439

STATUTORY AUTHORITY: 196.035, 197.020, 439.470, 439.590, 439.640

NECESSITY, FUNCTION, AND CONFORMITY: KRS 196.035, 197.020, 439.470, 439.590, and 439.640 authorize the Justice Cabinet and Department of Corrections to promulgate administrative regulations necessary and suitable for the proper administration of the department or any 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 Green River Correctional Complex.

Section 1. Incorporation by Reference. (1) "Green River Correctional Complex Policies and Procedures", ***April 14[February 13]***, 2014[~~November 15, 2007~~], is incorporated by reference. Green River Correctional Complex Policies and Procedures include:

GRCC 01-06-01 Inmate Access to and Communication with GRCC Staff (Amended 11/15/07)
GRCC 01-07-01 Institutional Tours of GRCC (Amended 11/15/07)
GRCC 01-08-01 GRCC Cooperation with Outside Bodies Including Courts, Governmental, Legislative, Executive, and Community Agencies (Amended 11/15/07)
GRCC 01-12-01 Public Information and Media Communication (Amended 11/15/07)
GRCC 01-13-01 Tobacco Free ***(Amended 4/14/14)[(Added 2/13/14)]***
GRCC 02-01-02 Fiscal Management: Accounting Procedures (Amended 11/15/07)
GRCC 02-01-03 Fiscal Management: Agency Funds (Amended 11/15/07)
GRCC 02-06-01 Inmate Canteen (Amended 11/15/07)
GRCC 02-06-02 Inmate Canteen Committee (Amended 11/15/07)
GRCC 02-07-01 Inmate Personal Funds (Amended 11/15/07)
GRCC 03-12-01 Confidentiality of Information, Roles and Services of Consultants, Contract Personnel, Volunteers, and Student Interns (Amended 11/15/07)
GRCC 05-02-01 Outside Consultation and Research (Amended 11/15/07)
GRCC 06-01-01 Offender Records (Amended ***4/14/14[2/13/14]***)
GRCC 08-02-01 Fire Safety (Amended ***4/14/14[2/13/14]***[~~11/15/07~~])
GRCC 09-01-01 Inmate Counts (Amended ***4/14/14[2/13/14]***[~~11/15/07~~])
GRCC 09-02-01 Inmate Unauthorized Substance[~~Drug~~] Abuse Testing (Amended 2/13/14[~~11/15/07~~])
GRCC 09-04-01 Inmate Death (Amended 2/13/14[~~11/15/07~~])
GRCC 10-01-01 Special Management Unit (Amended 11/15/07)
GRCC 11-01-01 Food Service: General Guidelines (Amended ***4/14/14[2/13/14]***[~~11/15/07~~])
GRCC 11-02-01 Food Service: Security (Amended 2/13/14[~~11/15/07~~])
GRCC 11-03-01 Dining Room Guidelines (Amended 2/13/14[~~11/15/07~~])
GRCC 11-04-01 Food Service: Meals (Amended 2/13/14[~~11/15/07~~])
GRCC 11-04-02 Food Service: Menu, Nutrition and Restricted Diets (Amended 2/13/14[~~11/15/07~~])
GRCC 11-06-01 Health Requirements of Food Handlers (Amended 11/15/07)
GRCC 11-07-01 Food Service: Inspections and Sanitation (Amended 2/13/14[~~11/15/07~~])
GRCC 12-01-01 Clothing, Bedding, Hygiene Supplies, and Barber Shop (Amended ***4/14/14[2/13/14]***[~~11/15/07~~])
GRCC 13-02-01 Medical Services: Sick Call, Physician's Clinics and Pill Call (Amended 9/14/2005)
GRCC 13-02-02 Medical Services: Copayment (Amended 9/14/2005)
GRCC 13-02-03 Continuing of Care: Health Evaluations, Intrasystem Transfer, Individual Treatment Plans (Amended 9/14/2005)
GRCC 13-03-01 Use of Pharmaceutical Products (Amended 9/14/2005)
GRCC 13-04-01 Health Records (Amended 9/14/2005)
GRCC 13-04-02 Psychological and Psychiatric Reports (Amended 11/8/2005)
GRCC 13-05-01 Management of Serious and Infectious Diseases (Amended 9/14/2005)
GRCC 13-06-01 Mental Health Services (Amended 9/14/2005)
GRCC 13-07-01 Medical Restraints (Amended 9/14/2005)
GRCC 13-08-01 Eye Care (Amended 9/14/2005)
GRCC 13-09-01 Dental Care (Amended 9/14/2005)
GRCC 13-10-01 Transfers and Medical Profiles (Amended 9/14/2005)
GRCC 13-11-01 Informed Consent (Amended 9/14/2005)
GRCC 13-12-01 Infirmary Care (Amended 9/14/2005)
GRCC 13-13-01 Inmate Self-administration of Medication (Amended 9/14/2005)
GRCC 13-15-01 Health Education Program and Detoxification (Amended 9/14/2005)
GRCC 14-01-01 Inmate Rights and Responsibilities (Amended 11/15/07)
GRCC 14-02-01 Legal Services Program (Amended 11/15/07)
GRCC 16-01-01 Inmate Visiting (Amended ***4/14/14[2/13/14]***[~~11/15/07~~])
GRCC 16-02-02 Inmate Correspondence and Privileged Mail (Amended 2/13/14[~~11/15/07~~])
GRCC 16-03-01 Inmate Telephone Communications (Amended 11/15/07)
GRCC 16-04-01 Inmate Packages (Amended 11/15/07)
GRCC 17-01-01 ***[~~GRCC~~]*** Inmate Property Control (Amended 2/13/14[~~11/15/07~~])
GRCC 17-02-01 GRCC Inmate Receiving and Orientation Process (Amended 11/15/07)
GRCC 17-03-01 Procedure for Sending Televisions to Outside Dealer for Repair (Amended 11/15/07)
GRCC 18-01-01 Inmate Classification (Amended 11/15/07)
GRCC 18-02-01 Meritorious Housing (Amended 2/13/14[~~11/15/07~~])
GRCC 18-02-02 Meritorious Visitation Program (Amended 2/13/14[~~11/15/07~~])
GRCC 18-03-01 Minimum Security Unit: Operating Procedures and Living Conditions (Added 11/15/07)
GRCC 19-01-01 Inmate Work Program (Amended 11/15/07)
GRCC 19-01-02 90-Day Unassigned Status (Amended 2/13/14[~~11/15/07~~])
GRCC 20-01-01 Educational Programs (Amended 11/15/07)
GRCC 21-01-01 Library Services (Amended 2/13/14[~~11/15/07~~])
GRCC 22-01-01 Recreation Programs (Amended 11/15/07)
GRCC 22-02-01 Inmate Clubs and Organizations (Amended 2/13/14[~~11/15/07~~])
GRCC 22-04-01 Arts and Crafts Projects (Amended 11/15/07)
GRCC 22-05-01 Inmate Photo Project (Amended 2/13/14[~~11/15/07~~])
GRCC 23-01-01 Religious Programs (Amended 11/15/07)
GRCC 23-02-01 Death or Hospitalization of an Inmate's Family Member and Notification of Inmates (Amended 2/13/14[~~11/15/07~~])
GRCC 24-01-01 Social Services and Counseling Program (Amended 11/15/07)
GRCC 25-01-01 Prerelease Program (Amended 11/15/07)
GRCC 25-01-02 Inmate Release Process (Amended 11/15/07)
GRCC 25-02-01 Parole Hearing Procedure (Amended 11/15/07)
GRCC 26-01-01 Citizen Involvement and Volunteer Services Program (Amended 2/13/14[~~11/15/07~~])

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Justice and Public Safety Office, Office of Legal Services, 125 Holmes Street, 2nd Floor, Frankfort, Kentucky 40601, phone (502) 564-8215, fax (502) 564-6686 Monday through Friday, 8 a.m. to 4:30 p.m.

LADONNA H. THOMPSON, Commissioner
APPROVED BY AGENCY: February 10, 2014
FILED WITH LRC: February 13, 2014 at 2 p.m.
CONTACT PERSON**:** Amy V. Barker, Assistant General Counsel, Department of Justice & Public Safety Cabinet, 125 Holmes Street, Frankfort, Kentucky 40601, phone (502) 564-3279, fax (502) 564-6686.

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Kentucky Board of Education
Department of Education
(As Amended at ARRS, April 14, 2014)

702 KAR 3:300. Approval for school district lease and retirement incentive annuity agreements.

RELATES TO: KRS 65.944, 65.946, 156.070
STATUTORY AUTHORITY: KRS 65.944(1)***(b)[~~(c)~~]***, 156.070, 156.160
NECESSITY, FUNCTION, AND CONFORMITY: KRS 156.160 and 156.070 ***require[~~give~~]*** the Kentucky Board of Education ***[~~the authority~~]*** to promulgate administrative regulations ***concerning[~~deemed necessary for~~]*** the management of the school districts. KRS 65.944(1)(b)[~~(c)~~] requires the Kentucky Board of Education to promulgate ***administrative regulations[~~an administrative regulation~~]*** to implement requirements for lease approval by the Commissioner of Education. This administrative regulation establishes requirements for approval of school district lease and retirement incentive annuities.

Section 1. Administrative Guidelines. (1) To request approval of a lease or retirement incentive annuity agreement in excess of $100,000 from the Commissioner of Education pursuant to KRS 65.944(1)***(b)[~~(c)~~]***, the following shall be submitted to the Department of Education, Office of Administration and Support[~~District Support Services~~], prior to finalization of the lease or retirement incentive annuity agreement:
(a) The terms of the lease or retirement incentive annuity, including the lease or retirement incentive annuity price;
(b) The number of optional renewal periods;
(c) The interest rate;
(d) The date of issue;
(e) The purpose of the lease or retirement incentive annuity; and
(f) The name of any trustee of paying agent.
(2) During the evaluation process, the Department of Education, Office of Administration and Support[~~District Support Services~~], may request additional documentation to properly evaluate the proposed lease or retirement incentive annuity agreement.

Section 2. Technology Leases. Pursuant to KRS 65.944(1)(b) and 65.946, each school district shall submit to the Department of Education, Office of Administration and Support[~~District Support Services~~], each technology lease including evidence of the lease being limited to the five (5)[~~three (3)~~] year useful life of the equipment and approval of the district's technology plan.

Section 3. Final Approval and Reconsideration. (1) Final approval of a proposed school district lease or retirement incentive annuity agreement with a lease or retirement incentive annuity price of $100,000 or more shall be granted by the Commissioner of Education before the agreement takes effect. ***Approval shall be granted if the lease complies with KRS 65.942(3).***
(2) Upon receiving approval from the Commissioner of Education, a school district may enter into the lease or retirement incentive annuity at any time within the current fiscal year.
(3)(a) The Commissioner of Education shall send written notification to the school district if the agreement is not approved.
(b) The notice shall contain the reasons the agreement was not approved.
(c) A school district may request reconsideration by the Commissioner of Education if alterations are made to the proposed lease or retirement incentive annuity which alleviate the concerns expressed by the Commissioner of Education.

Section 4. Superintendent Annuity. This administrative regulation shall not apply to an annuity provision within the negotiated employment contract of a school district superintendent.
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., Commissioner of Education
ROGER L. MARCUM, Chairperson
APPROVED BY AGENCY: February 14, 2014
FILED WITH LRC: February 14, 2014 at 11 a.m.
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.

PUBLIC PROTECTION CABINET
Kentucky Horse Racing Commission
(As Amended at ARRS, April 14, 2014)

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***(8)[(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 ***established in this section.[:]***

(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, 5α-estrane-3β, 17α-diol in urine or a ratio in urine of 5α-estrane-3β, 17α-diol to 5α-estrene-3β, 17α-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 of 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 alkalizing 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

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PUBLIC PROTECTION CABINET
Kentucky Horse Racing Commission
(As Amended at ARRS, April 14, 2014)

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.

(17)[(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.

(18)[(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.

(19)[(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.

(20)[(21)] If a person is excluded from a pari-mutuel association by the association, the commission shall be notified.

(21)[(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.

(22)[(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.

(23)[(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)***1. 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 penalties in subparagraphs 2 through 4 of this paragraph as deemed appropriate by the commission in keeping with the seriousness of the violation and the facts of the case:***

a. Flunixin (21-99 ng/ml); or

b. Ketoprofen (11-49 ng/ml).

2. For a first offense:

a. A suspension or revocation of licensing privileges from zero days to five (5) days; and

b. Payment of a fine of $250 to $500.

3. 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; and

b. Payment of a fine of $500 to $1,000.

4. 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;

b. Payment of a fine of $1,000 to $2,500; and

c. Forfeiture of purse money won[~~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.

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Office of the Kentucky Health Benefit Exchange
(As Amended at ARRS, April 14, 2014)

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. ***155.500-155.555[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. ***155.500 to 155.555[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***, 42 U.S.C. 18082***.

(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).

(4)[(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).

(5)[(6)] "Appellant" means the applicant or enrollee who is requesting an appeal.

(6)[(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 ***or[and]*** KCHIP, if applicable.

(7)[(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.

(8)[(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.

(9)[(10)] "DAH" means the Division of Administrative Hearings of the Cabinet for Health and Family Services.

(10)[(11)] "DCBS" means the Department for Community Based Services.

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

(12)[(13)] "Enrollee" means an eligible individual enrolled in a qualified health plan.

(13)[(14)] "Exemption" means an exemption from the shared responsibility payment.

(14)[(15)] "Final order" is defined by KRS 13B.010(6).

(15)[(16)] "Hearing" is defined by KRS 13B.010(2).

(16)[(17)] "Hearing officer" means a hearing officer employed by DAH.

(17)[(18)] "Indian" is defined by 25 U.S.C. 450b(d).

(18)[(19)] "Judicial review" means a court's review of factual or legal findings of an administrative body.

(19)[(20)] "Kentucky Children's Health Insurance Program" or "KCHIP" means the separate child health program established by the Commonwealth of Kentucky under ***42 U.S.C. 1397aa to 1397mm[title XXI of the Social Security Act]*** in accordance with implementing regulations at 42 C.F.R. ***Part*** 457.

(20)[(21)] "Kentucky Health Benefit Exchange" or "KHBE" means the Kentucky state-based ***exchange conditionally approved by HHS pursuant to 45 C.F.R. 155.105 to offer a QHP beginning January 1, 2014,[health insurance marketplace]*** that includes an:

(a) Individual exchange; and

(b) Small Business Health Options Program.

(21)[(22)] "MAGI-based income" is defined by 42 C.F.R 435.603(e).

(22)[(23)] "Personally identifiable information" means any data about an individual that could potentially identify that individual.

(23)[(24)] "Qualified health plan" or "QHP" means a health plan that ***meets the standards described in 45 C.F.R. 156.200 to 156.295 and that*** has in effect a certification issued by the ***office[KHBE that it meets the standards described in 45 C.F.R. 156 subpart C]***.

(24)[(25)] "Recommended order" is defined by KRS 13B.010(5).

(25)[(26)] "Tax filer" is defined by 45 C.F.R. 155.300.

(26)[(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. ***155.300 to 155.355[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 ***155.610(i)[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 ***member[~~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 ***shows[~~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 ***or redetermine*** 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 ***process***.

(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 ***if the request:***

(a)[~~that~~] Was incorrectly delivered or mailed to a department or division of the Cabinet for Health and Family Services***; and***

(b)[~~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 ***(5)(b)[~~(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 ***process*** 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 ***be implemented[~~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. ***If an appellant wants to withdraw an appeal, the[~~An~~]*** appellant shall withdraw a request for an appeal:
(1) In writing;
(2) By phone by contacting the ***kynect[~~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. ***155.300 to 155.355[~~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 ***shall[~~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.

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.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Maternal and Child Health
(As Amended at ARRS, April 14, 2014)

902 KAR 4:030. Newborn screening program.

RELATES TO: KRS 214.155

STATUTORY AUTHORITY: KRS 194A.050, 211.090, 214.155

NECESSITY, FUNCTION, AND CONFORMITY: KRS 214.155 requires the Cabinet for Health and Family Services to operate a newborn screening program for inborn errors of metabolism and other inherited and congenital disorders and conditions, and to establish a schedule of fees to cover the actual costs to the cabinet for the program. This administrative regulation requires that infants be tested for inborn errors of metabolism and other inherited and congenital disorders and conditions as specified in KRS 214.155, and establishes the schedule of fees to cover actual costs of the newborn screening program.

Section 1. Definitions. (1) "Blood spot testing" means laboratory testing that is performed on newborn infants to detect a wide variety of inherited and congenital disorders and conditions by using a laboratory-authorized filter paper specimen card.

(2) "Critical congenital heart disease" or "CCHD" means an abnormality in the structure or function of the heart that exists at birth and places an infant at significant risk of disability or death if not diagnosed and treated soon after birth.

(3) "Diagnostic echocardiogram" means a test that uses ultrasound to provide an image of the heart that is performed by a technician trained to perform pediatric echocardiograms.

(4) "Laboratory" means the Division of Laboratory Services within the Cabinet for Health and Family Services, Department for Public Health.

(5) "Pediatric cardiologist" means a pediatrician that is board-certified to provide pediatric cardiology care.

(6)[~~(2)~~] "Program" means the Newborn Screening Program for inherited and congenital[~~heritable~~] disorders and conditions operated by the Cabinet for Health and Family Services, Department for Public Health.

(7) "Pulse oximetry testing" means a noninvasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen.

(8)[~~(3)~~] "Submitter" means ***a[~~any~~]*** hospital, primary care provider, health department, birthing center, laboratory, or midwife submitting an infant's blood specimen for the purpose of newborn screening.

Section 2. Tests for inborn errors of metabolism or other inherited or congenital disorders and conditions for newborn infants as part of newborn screening shall include ***the following[~~all conditions consistent with the recommendations of the American College of Medical Genetics (ACMG)~~]***[~~the following tests~~]:

(1) 2-Methyl-3-hydroxybutyric aciduria (2M3HBA);
(2) 2-Methylbutyryl-CoA dehydrogenase deficiency (2MBDH);
(3) 3-Methylcrotonyl-CoA carboxylase deficiency (3MCC);
(4) 3-Methylglutaconic aciduria (3MGA);
(5) 3-Hydroxy 3-Methylglutaric aciduria (HMG);
(6) Argininemia (ARG);
(7) Argininosuccinic acidemia (ASA);
(8) Beta-ketothiolase deficiency (BKT);
(9) Biotinidase disorder (BIOT);
(10) Carnitine acylcarnitine translocase deficiency (CACT);
(11) Carnitine palmitoyl transferase deficiency I (CPT-I);
(12) Carnitine palmitoyl transferase deficiency II (CPT-II);
(13) Carnitine uptake defect (CUD);
(14) Citrullinemia type I (CIT-I);
(15) Citrullinemia type II (CIT-II);
(16) Congenital adrenal hyperplasia (CAH);
(17) Congenital hypothyroidism (CH);
(18) Critical congenital heart disease (CCHD);
(19) Cystic fibrosis (CF);
(20) Ethylmalonic encephalopathy (EE);
(21) Galactosemia (GAL);
(22) Glutaric acidemia type I (GA I);
(23) Glutaric acidemia type II (GA-II);
(24) Homocystinuria (HCY);
(25) Hypermethioninemia (MET);
(26) Hyperphenylalinemia (H-PHE);
(27) Isobutyryl-CoA dehydrogenase deficiency (IBG);
(28) Isovaleric acidemia (IVA);
(29) Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCAD);
(30) Malonic academia (MAL);
(31) Maple syrup urine disease (MSUD);
(32) Medium-chain acyl-CoA dehydrogenase deficiency (MCAD);
(33) Methylmalonic acidemia (Cbl A,B);
(34) Methylmalonic acidemia (Cbl C,D);
(35) Methylmalonic acidemia mutase deficiency (MUT);
(36) Multiple carboxylase deficiency (MCD);
(37) Non-ketotic Hyperglycinemia (NKHG);
(38) Phenylketonuria (PKU);
(39) Propionic ***acidemia[~~academia~~]*** (PA);
(40) ***Severe combined immunodeficiency (SCID);***
(41) Short-chain acyl-CoA dehydrogenase deficiency (SCAD);
(42)[~~(41)~~] Sickle cell disease (Hb S/S);
(43)[~~(42)~~] Sickle cell hemoglobin C disease (Hb S/C);
(44)[~~(43)~~] Sickle cell S Beta Thalassemia (Hb S/Th);
(45)[~~(44)~~] Trifunctional protein deficiency (TFP);
(46)[~~(45)~~] Tyrosinemia type I (TYR-I);
(47)[~~(46)~~] Tyrosinemia type II (TYR-II);
(48)[~~(47)~~] Tyrosinemia type III (TYR-III);
(49)[~~(48)~~] Various Hemoglobinopathies (includes Hb E); and
(50)[~~(49)~~] Very long-chain acyl-CoA deficiency (VLCAD)[~~3-methylcrotonyl-CoA carboxylase deficiency (3MCC);~~
~~(2) 3-OH 3-CH3 glutaric aciduria (HMG);~~
~~(3) Argininosuccinic acidemia (ASA);~~
~~(4) Beta-ketothiolase deficiency (BKT);~~
~~(5) Biotinidase disorder;~~
~~(6) Carnitine uptake defect (CUD);~~
~~(7) Citrullinemia (CIT);~~
~~(8) Congenital adrenal hyperplasia (CAH);~~
~~(9) Congenital hypothyroidism;~~
~~(10) Cystic fibrosis (CF);~~

~~(11) Galactosemia;~~
~~(12) Glutaric acidemia type I (GA I);~~
~~(13) Hb S/beta-thalassemia (Hb S/Th);~~
~~(14) Hb S/C disease (Hb S/C);~~
~~(15) Homocystinuria (HCY);~~
~~(16) Isovaleric acidemia (IVA);~~
~~(17) Long-chain L-3-OH acyl-CoA dehydrogenase deficiency (LCHAD);~~
~~(18) Maple syrup urine disease (MSUD);~~
~~(19) Medium-chain acyl-CoA dehydrogenase deficiency (MCAD);~~
~~(20) Methylmalonic acidemia (Cbl A,B);~~
~~(21) Methylmalonic acidemia mutase deficiency (MUT);~~
~~(22) Multiple carboxylase deficiency (MCD);~~
~~(23) Phenylketonuria (PKU);~~
~~(24) Propionic acidemia (PA);~~
~~(25) Short-chain acyl-CoA dehydrogenase deficiency (SCAD);~~
~~(26) Sickle cell disease;~~
~~(27) Trifunctional protein deficiency (TFP);~~
~~(28) Tyrosinemia type I (TYR I); and~~
~~(29) Very long-chain acyl-CoA deficiency (VLCAD)~~].

Section 3. Submitter Responsibilities. (1) Except as provided in KRS 214.155***(3) and*** (5)[~~(4)~~], the administrative officer[~~,~~] or other person in charge of the hospital or institution caring for newborn infants[~~,~~] and the attending primary care provider[~~physician~~] or midwife shall administer to, or verify administration of tests to, every infant in its care prior to hospital discharge:

(a)[~~,~~] A blood spot test to detect inborn errors of metabolism ***and[~~or~~]*** other inherited and congenital disorders and conditions identified in Section 2 of this administrative regulation; and

(b) Pulse oximetry testing to detect critical congenital heart disease[~~prior to hospital discharge~~].

(2) If a baby is not born in a hospital or institution, the attending primary care provider[~~physician~~] or midwife shall ensure[~~be responsible for ensuring~~] that both[~~these~~] tests required by subsection (1) of this section are:

(a) Administered between twenty-four (24) and forty-eight (48) hours of age;

(b) Acted ***upon[~~up~~]*** if abnormal; and

(c) Reported to the program ***by fax or by[~~using~~]*** the cabinet's web-based system.

(3)[~~2~~] A capillary blood spot specimen shall be obtained from a newborn infant[~~,~~] not requiring an extended stay due to illness or prematurity[~~,~~] between twenty-four (24) and forty-eight (48) hours of age.

(4)[~~3~~] If the infant is to remain in the hospital due to illness or prematurity, the hospital shall obtain the capillary blood spot specimen from that infant after twenty-four (24) and before seventy-two (72) hours of age.

(5) ***Except as provided by subsection (6) of this section,*** the pulse oximetry testing shall be performed when the infant is twenty-four (24) hours of age or older and shall occur prior to***[~~, but no later than, the day of~~]*** discharge.

(6) If the infant is discharged prior to twenty-four (24) hours of age, the blood spot and pulse oximetry testing shall be performed as close to twenty-four (24) hours of age as possible.

(7)[4] If an infant is transferred from the birth hospital to another hospital during the newborn hospital stay, the [~~following~~] rules established in this subsection shall apply.[~~:~~]

(a) The sending hospital shall obtain the capillary blood spot specimen for the newborn screening blood test and the pulse oximetry testing for CCHD if the infant is twenty-four (24) hours of age or more when the infant is transferred to another hospital.

(b) The receiving hospital shall ensure the newborn screening blood spot test and the pulse oximetry testing are[~~is~~] performed if the infant is less than twenty-four (24) hours of age when the infant is transferred.

(8) If an infant expires before the newborn screening blood spot test and pulse oximetry test have been performed, the program shall be notified within five (5) calendar days.

(9)[~~5~~] If the information on the filter paper specimen card obtained by the submitter and sent to the laboratory is incomplete or inadequate, then the submitter, upon request of the program, shall:

(a) Attempt[~~use all reasonable efforts~~] to locate the infant and obtain a complete and adequate specimen within ten (10) days; and

(b) Report to the program a[~~. If the submitter is unable to obtain the~~] specimen that is unable to be obtained within ten (10) days[~~, this shall be reported to the program~~].

(10) Submitters[~~(6)~~] that are responsible for the collection of the initial blood spot specimen and pulse oximetry testing for newborn screening shall:

(a) Provide to an infant's parent or guardian educational materials regarding newborn screening and pulse oximetry testing;

(b) Designate a newborn screening coordinator and physician responsible for the coordination of the facility's newborn screening compliance by having a newborn screening protocol;

(c) Notify the program of the name of the individuals designated in paragraph[~~subsection (6)~~] (b) of this ***subsection[~~section~~]*** each year in January and if the designated individual changes; and[~~;~~]

(d) Develop a written protocol for tracking newborn screening compliance which[~~. This protocol~~] shall:

1. Be submitted to the program each year in January; and

2. Include, at a minimum:[~~. The protocol shall include~~]

a. A requirement that the name of the primary care provider that will be[~~physician~~] attending the infant after birth or discharge or, if known, the primary care provider who will be caring for the infant after discharge, shall[~~or a designee~~] be placed on the filter paper specimen card sent with the initial blood spot specimen to the laboratory. If the infant is in the neonatal intensive care unit, the name of the attending neonatologist may be placed on the filter specimen card sent with the initial blood spot specimen to the laboratory;

b.[~~2. The protocol shall include~~] Verification that:

(i) Each infant born at that facility has had a specimen obtained for newborn screening and pulse oximetry testing on or before discharge;

(ii) All information on the specimen card has been thoroughly completed; and

(iii) The specimen has been submitted appropriately;

c. A process to ensure that final results of the pulse oximetry screening are entered into the Cabinet's web-based system; and

d. A procedure to assure the hospital or facility[~~and notification shall occur to the program within seven (7) days if any infant is missed; and~~

~~3. The hospital or facility~~] that identifies that an infant has not had a specimen obtained for newborn screening and pulse oximetry testing prior to discharge shall:

(i) Notify the program;

(ii) Use every reasonable effort to locate the infant;

(iii) Notify the parent or guardian and the primary care provider immediately; and

(iv) Recommend that the infant present to the hospital or primary care provider immediately for a newborn screening blood spot specimen and pulse oximetry testing[~~use every reasonable effort to locate the infant and recommend that they present to the hospital or their primary care provider for a newborn screening specimen to be obtained~~].

(11)[~~(c)~~] Hospitals or facilities shall report all written refusals, in accordance with KRS 214.155***(5)[~~(4)~~]***, to the program within five (5) calendar[~~seven (7)~~] days.

Section 4. Blood Specimen Collection. (1) Capillary blood spot specimens required in Section 3 of this administrative regulation shall be obtained by a heel stick.

(2) Blood from the heel stick shall be applied directly to filter paper specimen card.

(3) All circles shall be saturated completely using a drop of blood per circle on a filter paper specimen card.

(4) The specimen collector shall provide, on the filter paper specimen card, information requested by the laboratory.

(5)[~~(2)~~] The capillary blood spot specimen shall be air dried for three (3) hours and then shall be mailed or sent to the laboratory:

(a) Within twenty-four (24) hours of collection of the specimen; or

(b) The next business day in which mail or delivery service is available.

(6)[(3)] Submitters sending[send] blood spot specimens via regular mail services shall ***send[ensure]*** the specimens ***[are sent]*** to the following address:[to the] Cabinet for Health and Family Services, Department for Public Health, Division of Laboratory Services, P.O. Box 2010, Frankfort, Kentucky 40602.

(7) Submitters sending blood spot specimens via expedited mail services shall ensure the specimens are sent to the following address: Cabinet for Health and Family Services, Department for Public Health, Division of Laboratory Services, 10 Sower Boulevard, Suite 204, Frankfort, Kentucky 40602.

(8)[(4)] Specimens processed or tracked under the newborn screening program shall be limited to specimens on infants less than six (6) months of age.

Section 5. Unsatisfactory or Inadequate Blood Specimen. (1) If a specimen is unsatisfactory or inadequate to produce a valid result, the laboratory shall notify the submitter and the parent[primary care provider] on the filter paper specimen card[by mail] that the newborn screen needs to be repeated as soon as possible.

(2) If a requested repeat specimen has not been received within ten (10) business days from the date the repeat request was issued, the program[laboratory] shall notify the parent by mail of the need for a repeat screening test.

Section 6. Special Circumstances - Blood Transfusion. If a newborn infant requires a blood transfusion, the following rules for newborn screening shall apply:

(1) The hospital shall obtain a capillary blood sample for newborn screening prior to the infant being transfused, except in an emergency situation.

(2) If the pre-transfusion sample was obtained before twenty-four (24) hours of age, or if it was not obtained due to an emergency situation, then the hospital or primary care provider shall use all reasonable efforts to obtain a repeat capillary blood specimen from the transfused infant and submit it to the laboratory according to the following schedule:

(a) Seventy-two (72) hours after last blood transfusion, rescreen for inborn errors of metabolism and inherited and congenital disorders and conditions listed in Section 2 of this administrative regulation; and

(b) Ninety (90) days after last blood transfusion, rescreen for any disorder that relies on red blood cell analysis such as hemoglobinopathies, galactosemia, and biotinidase deficiency.

Section 7. Reporting[of] Results of Newborn Screening Blood Tests. (1) Normal Results. Upon receipt of normal lab results, the laboratory shall mail results to the primary care provider and the submitter.

(2) Abnormal Results.

(a) Submitters and primary care providers shall receive a copy of all abnormal, presumptive positive, and equivocal results by mail.

(b) In addition to receiving mailed results, primary care providers shall be notified of abnormal, presumptive positive, and equivocal results in the following manner:

1. Upon receipt of an abnormal, equivocal, or a presumptive positive lab result, the laboratory[program] shall[immediately] notify the primary care provider listed on the filter paper specimen card within two (2) business days of the result and the need for[recommend appropriate] follow-up testing.

2. Upon receipt of a presumptive positive lab[an equivocal result] result, the program shall notify the primary care provider listed on the filter paper specimen card[within two (2) business days] of the result and recommend immediate consultation with a university pediatric specialist[next step recommendations].

3. If the program is unable to determine the infant's[ascertain a correct] primary care provider to notify them of abnormal, presumptive positive, or equivocal results and the need for follow-up, the program[for a specimen to be obtained, for repeat screen or referral, they] shall use every available means to ***notify the infant's parent[ensure]***[contact]***[the parent of the infant has been notified]***.

(c) The Cabinet for Health and Family Services shall share pertinent test results with state university-based specialty clinics or primary care providers who inform the cabinet[that] they are treating the infant who received the test.

(d) The cabinet[, and] may share pertinent test results with the local health department in the infant's county of residence that conducts newborn screening follow-up activities.

(e) These specialty clinics or primary care providers shall report results of diagnostic testing to the program within thirty (30) days or earlier upon request.

(f)[(d)] The laboratory shall report abnormal, presumptive positive, or equivocal results of tests for inborn errors of metabolism,[and] inherited and congenital disorders and conditions[inborn errors of metabolism] to the program[on behalf of the hospitals and submitters].

(g)[(e)] If a requested repeat specimen has not been received within ten (10) business days from the date the repeat request was issued, the program shall notify the parent by mail of the need for a repeat screening test.

Section 8. Pulse oximetry screening for critical congenital heart disease. Pulse oximetry screening for critical congenital heart defects required by Section 2 of this administrative regulation shall be consistent with the standard of care according to national recommendations by the American Academy of Pediatrics.

Section 9. Pulse Oximetry Screening Process. (1) ***Except as provided by KRS 214.155(3) and subsections (2) and (4) of this section,*** pulse oximetry testing shall be performed when the infant is between twenty-four (24) and forty-eight (48) hours of age and shall occur no later than the day of discharge.

(2) If the infant is discharged prior to twenty-four (24) hours of age, the blood spot and pulse oximetry testing shall be performed as close to twenty-four (24) hours of age as possible.

(3) Infants in neonatal intensive care units shall be screened when medically appropriate after twenty-four (24) hours of age but prior to discharge.

(4) Infants who have been identified with critical congenital heart disease prior to birth or prior to twenty-four (24) hours of age shall be exempt from the pulse oximetry screening process.

(5) Pulse oximetry screening shall be performed by placing pediatric pulse oximetry sensors simultaneously on the infant's right hand and either foot to obtain oxygen saturation results.

(6) If using a single pediatric pulse oximetry sensor, pulse oximetry screening shall be performed on the infant's right hand and either foot, one after the other, to obtain oxygen saturation results.

Section 10. Pulse Oximetry Testing Results. (1) A passed result shall ***not*** require***[no]*** further action if:

(a) The pulse oximetry reading in both extremities is greater than or equal to ninety-five (95) percent; and

(b) The difference between the readings of both the upper and lower extremity is less than or equal to three (3) percent.

(2)(a) A pending result shall:

1. Occur if:

a. The pulse oximetry reading is between ninety (90) and ninety-four (94) percent; or

b. The difference between the readings of both the upper and lower extremity is greater than three (3) percent; and

2. Be repeated using the pulse oximetry screening in one (1) hour.

(b) If a repeated pulse oximetry screen is also interpreted as pending, it shall be performed ***again*** in one (1) hour.

(c) If the pulse oximetry result on the third screen continues to meet the criteria as pending after three (3) screenings have been performed, it shall be considered failed ***and the procedures established in subsection (3) of this section shall be followed***.

(3) A failed result shall occur if the initial pulse oximetry reading

is less than ninety (90) percent in the upper or lower extremity and shall require the following action:

(a) The primary care provider shall be notified immediately;

(b) The infant shall be evaluated for the cause of the low saturation reading; and

(c) If CCHD cannot be ruled out as the cause of the low saturation reading, the attending physician or advanced practice registered nurse shall:

1. Order a diagnostic echocardiogram to be performed without delay;

2. Ensure the diagnostic echocardiogram be interpreted as soon as possible; and

3. If the diagnostic echocardiogram results are abnormal, obtain a consultation with a pediatric cardiologist prior to hospital discharge.

Section 11. Reporting Results of Pulse Oximetry Screening. (1) Final results of the pulse oximetry screening shall be entered into the cabinet's web-based system.

(2) A failed result shall be immediately reported to the program ***by fax or by the cabinet's web-based system[~~as specified by the cabinet~~]***.

Section 12. Newborn Screening Fees. (1) Submitters obtaining and sending a blood specimen to the laboratory shall be billed a fee of $53.50 for the initial newborn screening test.

(2) Submitters obtaining and sending a repeat blood specimen to the laboratory shall not be charged an additional fee of $53.50.

(3) Fees due the Cabinet for Health and Family Services shall be collected through a monthly billing system.

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

APPROVED BY AGENCY: December 10, 2013

FILED WITH LRC: December 11, 2013 at 1 p.m.

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

ADMINISTRATIVE REGULATIONS AMENDED AFTER PUBLIC HEARING OR RECEIPT OF WRITTEN COMMENTS

TRANSPORTATION CABINET
Department of Highways
Division of Maintenance
(Amended After Comments)

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).

(8)[~~(9)~~] "Commercial or industrial business" means **an activity on an interstate or parkway generally recognized as commercial or industrial by local zoning authorities. The following shall not be considered a commercial or industrial business:**

(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; or

(h) A facility generally recognized as a utility.

(9)[~~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 **four (4)[~~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.

(10)[~~(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).

(11)[~~(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.

(12)[~~(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 **tortious[~~torturous~~]** acts.

(13)[~~(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.

(14)[~~(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.

(15)[~~(19)~~] "Extension" means an addition to a static advertising device **not in excess of fifteen (15) percent of the[~~in excess of the static advertising~~]** device's face.

(16)[~~(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.

(17)[~~(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.

(18)[~~(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/.

(19)[~~(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.

(20)[~~(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/.

(21)[~~(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.

(22)[~~(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/.

(23)[~~(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.

(24)[~~(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."

(25)[~~(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.

(26)[~~(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.

(27)[~~(32)~~] "Obsolete" means an advertisement that is out-of-date by thirty (30) days or more, or is no longer discernible.

(28)[~~(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.

(29)[~~(34)~~] "Off-premise advertising device" means an off-premise electronic advertising device and an off-premise static advertising device.

(30)[~~(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.

(31)[~~(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.

(32)[~~(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.

(33)[~~(38)~~] "On-premise advertising device" means an on-premise electronic advertising device and an on-premise static advertising device.

(34)[~~(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.

(35)[~~(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 an interstate, parkway, national highway system, or federal-aid primary highway.

(36)[~~(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.

(37)[~~(42)~~]"Parkway" means as formally designated by the Transportation Cabinet on http://maps.kytc.ky.gov/PAFOA/.

(38)[~~(43)~~] "Permitted" means authorized to exist only if a permit is issued from the Department of Highways.

(39)[~~(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.

(40)[~~(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.

(41)[~~(47)~~] "Scenic byway" is defined by KRS 177.572.

(42)[~~(48)~~] "Scenic highway" is defined by KRS 177.572.

(43)[~~(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.

(44)[~~(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.

(45)[~~(51)~~] "Static advertising device" means an advertising device that does not use electric or mechanical technology to change the message.

(46)[~~(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.

~~(47)[(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.

(48)[~~(57)~~] "Unzoned commercial or industrial area" is defined by KRS 177.830(8).

(49)[~~(58)~~] "Urban area" is defined by KRS 177.830(10).

(50)[~~(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.

(51)[~~(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.

(52)[~~(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: April 14, 2014

FILED WITH LRC: April 15, 2014 at 10 a.m.

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 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
(Amended After Comments)

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 **may be erected[~~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 **may[~~shall not~~]** contain extensions **up to fifteen (15) percent of the face of the advertising device[~~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.

(i)[~~(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.

(j)[~~(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.[~~6.~~] The addition of variable or changeable message capability;

6.[~~7.~~] The addition of bracing, guy wires, or other reinforcement;

7.[~~8.~~] A change in the location of the structure; or

8.[~~9.~~] A change in the direction of the face.

(g) Performance of non-routine maintenance on a non-conforming 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 **four (4)[~~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 **four (4)[~~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 non-conforming 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 permittable, 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 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 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
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
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) Calloway 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 Pennyrile Parkway.~~	~~.000~~	~~13.611~~
~~US 41LP - From KY 107 to northwest urban limits of Hopkinsville at KY 91/1682.~~	~~.000~~	~~5.100~~
~~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 Pennyrile 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 Pennyrile 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~~
~~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 Pennyrile Parkway to Indiana State Line (north urban limits of Henderson).~~	~~13.414~~	~~21.193~~
~~US 41A - From Dixon Street to the northern most 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 Pennyrile 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~~
~~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 Pennyrile 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:~~		
~~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
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 Vicco 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
(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 DANGELO, Office of Legal Services

APPROVED BY AGENCY: April 14, 2014

FILED WITH LRC: April 15, 2014 at 10 a.m.

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.

TRANSPORTATION CABINET
Department of Highways
Division of Maintenance
(Amended After Comments)

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; **or**

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.

(f)[~~(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 **672[~~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 **four (4)[~~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 **four (4)[~~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 permittable 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 **off-premise** 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: April 14, 2014

FILED WITH LRC: April 15, 2014 at 10 a.m.

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 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 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.

TRANSPORTATION CABINET
Department of Highways
Division of Maintenance
(Amended After Comments)

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 **frontage[~~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.

Section 2. View Permit Restrictions. (1) A view permittee shall 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 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: April 14, 2014

FILED WITH LRC: April 15, 2014 at 10 a.m.

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 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 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. 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? 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
Department for Medicaid Services
Division of Provider Operations
(Amended After Comments)

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 in-state specialist in hearing instruments shall:**

1. Maintain a current, unrevoked, and unsuspended license issued by the Kentucky Licensing Board for Specialists in Hearing Instruments;

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 specialist in hearing instruments 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 specialist in hearing instruments by the American Speech-Language-Hearing Association.

(b) An out-of-state **specialist in** hearing **instruments[~~instrument dispenser~~]** shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the licensing board with jurisdiction over **specialists in** hearing **instruments[~~instrument dispenser~~]** 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 **specialist in hearing instruments[~~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 **specialist in hearing instruments[~~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~~	~~Sinusodial vertical axis rotational testing~~
~~92547~~	~~Use of vertical electrodes~~

~~(b) Complete hearing evaluation;~~

~~(c)~~] 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.[~~(1)~~] 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: March 28, 2014

FILED WITH LRC: March 31, 2014 at 3 p.m.

CONTACT PERSON: Tricia Orme, email 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. The amendment after comments inserts requirements regarding in-state specialists in hearing instruments and corrects references/terminology of certain practitioners to "specialists in hearing instruments" rather than hearing instrument dispensers.

(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. The amendment after comments is necessary as DMS inadvertently omitted in-state specialists in hearing instruments' requirements and to correct terminology.

(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. The amendment after comments conforms to the content of the authorizing statutes by inserting inadvertently omitted requirements and correcting terminology for clarity.

(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. The amendment after comments conforms to the content of the authorizing statutes by inserting inadvertently omitted requirements and correcting terminology for clarity.

(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 Community Alternatives
(Amended After Comments)

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) **"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.

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

(6)[~~(5)~~] "Provider" is defined by KRS 205.8451(7).

(7) "Qualified mental health professional" means an individual who meets the requirements established in KRS 202A.0011(12).

(8)[~~(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) **Rehabilitative mental health and substance use disorder services including:**

1.[Inpatient services;

(b) Outpatient Services;

(c)] Individual **outpatient** therapy;

2.[(d)] Group **outpatient** therapy;

3.[(e)] Family **outpatient** therapy;

4.[(f)] Collateral **outpatient[services including collateral]** therapy;

5.[(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];

6.[(m) Evaluations, examinations, and testing including] Psychological testing;

7.[(n) Physical examinations;

(o) Services in a detoxification setting;

(p) Chemotherapy services;

(q)] Screening;

8.[(r)] An assessment;

9.[(s)] Crisis intervention;

10.[(t)] Service planning;

11.[(u)] A screening, brief intervention, and referral to treatment;

12.[(v)] Medication assisted treatment for a substance use disorder;

13.[(w)] Mobile crisis services;

14.[(x)] Assertive community treatment;

15.[(y)] Intensive outpatient program services;

16.[(z)] Residential crisis stabilization services;

17.[(aa)] Partial hospitalization;

18.[(bb)] Residential services for substance use disorders;

19.[(cc)] Day treatment;

20.[(dd)] Comprehensive community support services;

21.[(ee)] Peer support services; or

22.[(ff)] Parent or family peer support services**; or**

(b) Physical health services including:

1. Physical examinations; or

2. Medication prescribing and monitoring.

(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) 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 **fee-for-service** 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**[~~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, **on[during]** the same **day of service[~~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 **on the same day of service**.

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**, if available,** 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 **a licensed[~~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) **A provisional[~~An appropriate~~]** diagnosis;

(b) A referral for further consultation and disposition, if applicable; **or[~~and~~]**

(c)1. **If applicable,** termination of services and referral to an outside source for further services; or

2. **If applicable,** 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 **within ten (10) business days of the transfer or referral**.

(14)(a) If a **CMHC's[~~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 **regarding recipients to whom the CMHC has provided services[~~of the provider~~]** shall:

1. Remain the property of the **CMHC[~~provider~~]**; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A **CMHC[~~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 **CMHC[~~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 **CMHC[~~provider~~]** receives any duplicate payment or overpayment from the department, regardless of reason, the **CMHC[~~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 1:671].

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: April 11, 2014
FILED WITH LRC: April 14, 2014 at 11 a.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.) The amendment after comments inserts a definition of "face-to-face" which accommodates Telehealth as qualifying as "face-to-face"; inserts a definition of "qualified mental health professional"; synchronizes the names of covered services with the terminology approved by the Centers for Medicare and Medicaid Services (CMS); eliminates a duplicative requirement regarding electronic signatures; and clarifies miscellaneous provisions.

(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. The amendment after comments is necessary to synchronize terminology with what was approved by CMS and to clarify policies.

(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. The amendment after comments will conform to the content of the authorizing statutes by ensuring that the terminology comports with federal requirements and clarifying policies.

(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. The amendment after comments will assist in the effective administration of the authorizing statutes by ensuring that the terminology comports with federal requirements and clarifying policies

(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
(Amended After Comments)

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 **fee-for-service** 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 **Outpatient** Therapy	15 minutes
Group **Outpatient** Therapy	15 minutes
Family **Outpatient** Therapy	15 minutes
Collateral **Outpatient** 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
Medication Prescribing and Monitoring[~~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	**Per Diem[15 minutes]**
Mobile Crisis Services	**1 hour[15 minutes]**
Assertive Community Treatment	**Per Diem[15 minutes]**
Intensive Outpatient Program Services	**Per Diem[15 minutes]**
Residential Crisis Stabilization Services	**Per Diem[15 minutes]**
Residential Services for Substance Use Disorders	**Per Diem[15 minutes]**
Partial Hospitalization	**Per Diem[15 minutes]**
Day Treatment	**1 hour[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[audits] 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: April 11, 2014
FILED WITH LRC: April 14, 2014 at 11 a.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. The amendment after comments eliminates terms which are broad categories of services rather than specific services; corrects the unit of service duration for several services; updates the name for certain services; and eliminates the Community Mental Health Center Reimbursement Manual from the incorporated material.

(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. The amendments after comments which eliminates broad descriptive terms is necessary to eliminate confusion as it may be unclear which specific services fall under a given broad category and the broad category is unnecessary. Updating the names of certain services is also necessary to eliminate confusion.
Correcting the unit durations of certain services is necessary to synchronize the units with what was approved by the Centers for Medicare and Medicaid Services (CMS). Removing the Community Mental Health Center Reimbursement Manual from the incorporated material is necessary as the manual is no longer used.

(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. The amendments are comments will conform to the content of the authorizing statutes by clarifying policies/eliminating confusion and synchronizing policies with what was approved by CMS.

(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. The amendments are comments will assist in the effective administration of the authorizing statutes by clarifying policies/eliminating confusion and synchronizing policies with what was approved by CMS.

(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
(Amended After Comments)

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.

(5)[~~(6)~~] "Community support associate" means an individual who**:**

(a) Meets the community support associate requirements established in 908 KAR 2:250**; and**

(b) Has been certified by the Department for Behavioral Health, Intellectual and Developmental Disabilities as a community support associate.

(6)[~~(7)~~][~~(4)~~] "Department" means the Department for Medicaid Services or its designee.

(7)[~~(8)~~][~~(5)~~] "Emergency condition" means a condition or situation requiring an emergency service pursuant to 42 C.F.R. 447.53.

(8)[~~(9)~~] "Enrollee" means a recipient who is enrolled with a managed care organization.

(9)[~~(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.

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

(11)[~~(13)~~][~~(6)~~] "Federally-qualified health center" or "FQHC" is defined by 42 U.S.C. 1396d(l)(2)(B).

(12)[~~(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.

(13)[~~(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/.

(14)[~~(16)~~][~~(7)~~] "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(15)[~~(17)~~] "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(16)[~~(18)~~] "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(17)[~~(19)~~] "Licensed professional counselor associate" is defined by KRS 335.500(3).

(18)[~~(20)~~] "Licensed psychological associate" means**:**

(a) An individual who:

1.[~~(a)~~] Currently possesses a licensed psychological associate

license in accordance with KRS 319.010(6); and

2.[~~(b)~~] Meets the licensed psychological associate requirements established in 201 KAR Chapter 26**; or**

(b) A certified psychologist.

(19)[~~(21)~~] "Licensed psychological practitioner" means**;**

(a) An individual who meets the requirements established in KRS 319.053**; or**

(b) A certified psychologist with autonomous functioning.

(20)[~~(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.

(21)[~~(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.

(22)[~~(24)~~] "Marriage and family therapy associate" is defined by KRS 335.300(3).

(23)[~~(25)~~] "Medically necessary" means that a covered benefit or service is necessary in accordance with 907 KAR 3:130.

(24)[~~(26)~~][~~(8)~~] "Nurse-midwife" is defined by 42 C.F.R. 405.2401(b).

(25)[~~(27)~~][~~(9)~~] "Nutritionist" is defined by KRS 310.005(4).

(26)[~~(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).

(27)[~~(30)~~][~~(11)~~] "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(28)[~~(31)~~][~~(12)~~] "Primary care center" or "PCC" means an entity meeting the primary care center requirements established in 902 KAR 20:058.

~~(29)[(32) "Qualified mental health professional" is defined by KRS 202A.011(12).~~

~~(33)~~] "Recipient" is defined by KRS 205.8451(9).

(30)[~~(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 **practice** 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 **licensed[~~clinical~~]** psychologist, licensed clinical social worker, or advanced **practice** registered nurse**[~~practitioner~~]** within the provider's legally authorized scope of service; or

(b) Services or supplies incidental to a **licensed[~~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; **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 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;

(f) Individual outpatient therapy 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;

(g) Family outpatient therapy 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;

(h) Group outpatient therapy 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;

(i) Collateral outpatient therapy 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;

(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; **or**

3. An advanced practice registered nurse;

(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; **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;**~~**]**

(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; **or**

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;

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;

(p) Assertive community treatment provided by a team that includes 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;

(g)] Intensive outpatient program provided by**[a team that includes 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; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(o)[(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; **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; 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. **On-site at an FQHQ, FQHQ look-alike, or PCC**[~~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 **except for methadone**; 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.~~

~~(g)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 **prescribing and monitoring[~~management~~]**;

c. Adequate staffing to ensure a minimum recipient-to-staff ratio of **fifteen (15)[~~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.

~~(o)1.[(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) Diptheria 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 **fee-for-service** 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: April 11, 2014

FILED WITH LRC: April 14, 2014 at 11 a.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. The amendment after comments deletes peer support services and parent or family peer support services from the services covered under this administrative regulation; deletes peer support specialists, family peer support specialists, and youth peer support specialists as authorized practitioners of services in this administrative regulation; deletes mobile crisis services, assertive community treatment, residential crisis stabilization services, and residential services for substance use disorders from the services covered under this administrative regulation; clarifies that advanced practice registered nurses may provide medication assisted treatment; clarifies that "medication prescribing and monitoring" rather than "medication management" is the appropriate term; clarifies that a licensed psychological practitioner includes a certified psychologist with autonomous functioning; clarifies that "crisis intervention" must be provided on-site at an FQHC, FQHC look-alike, or PCC; and clarifies that a licensed psychological associate includes a certified psychologist.

(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. The amendments after comments which delete services and practitioners are necessary as the Centers for Medicare and Medicaid Services (CMS) did not approve those practitioners or services in the settings addressed in this administrative regulation and/or the services are beyond the scope of services authorized for these facilities pursuant to their licensure category. Adding advanced practice registered nurses to the authorized practitioners of medication assisted treatment is necessary as they are qualified to provide that service. Correcting the term "medication management" to "medication prescribing and monitoring" is necessary to comport with CMS guidance. Establishing that "crisis intervention" is covered when provided on-site is necessary to comport with the state plan amendment approved by CMS.

(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. The amendments after comments conform to the content of the authorizing statutes by synchronizing policies with those approved by CMS.

(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. The amendments after comments assist in the effective administration of the authorizing statutes by synchronizing policies with those approved by CMS.

(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
(Amended After Comments)

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.

(4)[~~(5)~~] "Community support associate" means an individual who**:**

(a) Meets the community support associate requirements established in 908 KAR 2:250**; and**

(b) Has been certified by the Department for Behavioral Health, Intellectual and Developmental Disabilities as a community support associate.

(5)[~~(6)~~][~~(3)~~] "Department" means the Department for Medicaid Services or its designee.

(6)[~~(7)~~] "Enrollee" means a recipient who is enrolled with a managed care organization.

(7)[~~(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.

(8)[~~(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.

(9)[~~(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/.

(10)[~~(12)~~][~~(4)~~] "Homebound recipient" is defined by 42 C.F.R. 440.20(b)(4)(iv).

(11)[~~(13)~~][~~(5)~~] "Intermittent nursing care" is defined by 42 C.F.R. 405.2401(b).

(12)[~~(14)~~][~~(6)~~] "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(13)[~~(15)~~] "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(14)[~~(16)~~] "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(15)[~~(17)~~] "Licensed professional counselor associate" is

defined by KRS 335.500(3).

(16)[(18)] "Licensed psychological associate" means**:**

(a) An individual who:

1.[(a)] Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

2.[(b)] Meets the licensed psychological associate requirements established in 201 KAR Chapter 26**; or**

(b) A certified psychologist.

(17)[(19)] "Licensed psychological practitioner" means**:**

(a) An individual who meets the requirements established in KRS 319.053**; or**

(b) A certified psychologist with autonomous functioning.

(18)[(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.

(19)[(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.

(20)[(22)] "Marriage and family therapy associate" is defined by KRS 335.300(3).

(21)[(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].

(22)[(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).

(23)[(26)][(10)] "Part-time nursing care" is defined by 42 C.F.R. 405.2401(b).

(24)[(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).

(25)[(29)][(12)] "Physician assistant" is defined by KRS 311.840(3) and 42 C.F.R. 405.2401(b).

(26)[(30) "Qualified mental health professional" is defined by KRS 202A.011(12).

(31)] "Recipient" is defined by KRS 205.8451(9).

(27)[(32)][(13)] "Rural health clinic" or "RHC" is defined by 42 C.F.R. 405.2401(b).

(28)[(33)][(14)] "State plan" is defined by 42 C.F.R. 400.203.

(29)[(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 **or[,]** 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 **except for services furnished by an APRN as these services shall not be required to be 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, **or** 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, **or** 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 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 **licensed[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 **licensed[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; **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 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;

(f) Individual outpatient therapy 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;

(g) Family outpatient therapy 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;

(h) Group outpatient therapy 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;

(i) Collateral outpatient therapy 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;

(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; **or**

3. An advanced practice registered nurse;

(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; **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;~~]

(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; **or**

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;

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;

(p) Assertive community treatment provided by a team that includes 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;

(g)] Intensive outpatient program provided by**[a team that includes 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; or
13. A physician assistant working under the supervision of a physician if the physician is the billing provider for the service;

(o)[(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; **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; 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. **On-site at a rural health clinic**~~[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 **except for methadone**; 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 **prescribing and monitoring[management]**;

c. Adequate staffing to ensure a minimum recipient-to-staff ratio of **fifteen (15) to one (1)[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.

(o)1.[(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 **fee-for-service** 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: April 11, 2014

FILED WITH LRC: April 14, 2014 at 11 a.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. The amendment after comments deletes peer support services and parent or family peer support services from the services covered under this administrative regulation; deletes peer support specialists, family peer support specialists, and youth peer support specialists as authorized practitioners of services in this administrative regulation; deletes mobile crisis services, assertive community treatment, residential crisis stabilization services, and residential services for substance use disorders from the services covered under this administrative regulation; clarifies that advanced practice registered nurses may provide medication assisted treatment; clarifies that "medication prescribing and monitoring" rather than "medication management" is the appropriate term; clarifies that a licensed psychological practitioner includes a certified psychologist with autonomous functioning; clarifies that a licensed psychological associate includes a certified psychologist; removes the requirement that services furnished by an advanced practice registered nurse (APRN) must be supervised by a physician; clarifies that "crisis intervention" must be provided on-site at the rural health clinic; and deletes the term "nurse midwife" from the administrative regulation.

(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. The amendments after comments which delete services and practitioners are necessary as the Centers for Medicare and Medicaid Services (CMS) did not approve those practitioners or services in the settings addressed in this administrative regulation and/or the services are beyond the scope of services authorized for these facilities pursuant to their licensure category. Adding advanced practice registered nurses to the authorized practitioners of medication assisted treatment is necessary as they are qualified to provide that service. Correcting the term "medication management" to "medication prescribing and monitoring" is necessary to comport with CMS guidance. Eliminating the requirement that an APRN be supervised by a physician is necessary as Kentucky law does not require this. Delete the term "nurse midwife" from the administrative regulation is necessary as nurse midwives are included in the definition of the term "advanced practice registered nurse." Clarifying that "crisis intervention" must occur on-site at the rural health clinic is necessary to comport with the state plan amendment approved by CMS.

(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. The amendments after comments conform to the content of the authorizing statutes by synchronizing policies with those approved by CMS.

(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. The amendments after comments assist in the effective administration of the authorizing statutes by synchronizing policies with those approved by CMS.

(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
(Amended After Comments)

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)(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) **"Community spouse" means the individual who is married to 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.

(2)[~~"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.

(3)[~~(2)~~][~~(4)~~] "Department" means the Department for Medicaid Services or its designee.

(4) "Dependent child" means a couple's child, including a child gained through adoption, who:

(a) Lives with the community spouse; and

(b) Is claimed as a dependent by either spouse under the Internal Revenue Service Code.

(5)[~~(3)~~] "DMEPOS" means durable medical equipment, prosthetics, orthotics, and supplies.

(6)[~~(4)~~][~~(5)~~] "Drug" means a covered drug provided in accordance with 907 KAR 1:019 for which the Department for Medicaid Services provides reimbursement.

(7)[~~(5)~~] "Enrollee" means a Medicaid recipient who is enrolled with a managed care organization.

(8)[~~(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).

(9)[~~(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.

(10)[~~(8)~~][~~(10)~~] "KCHIP - Separate Program" means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(11)[~~(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.

(12)[~~(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.

(13)[~~(11)~~][~~(13)~~] "Nonemergency" means a condition which does not require an emergency service pursuant to 42 C.F.R.

447.53.

(14)[(12)][(14)] "Nonpreferred brand name drug" means a brand name drug that is not on the department's preferred drug list.

(15)[(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.

(16)[(14)] "Preventive service" means:

(a)**1. All of the preventive services assigned a[For a child:**

1. An immunization recommended by the Centers for Disease Control; or

2. A preventive service:

a. Rated] grade **of** A or B by the United States Preventive Services Task Force (USPSTF); **or**

2. All approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices;

(b) Preventive care and screening for infants, children, and adults recommended by the Health Resources and Services Administration Bright Futures Program Project[and

b. Recommended for children and adolescents by the USPSTF]; or

(c) Preventive services for women recommended by the Institute of Medicine[(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].

(17)[(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].

(18)[(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 surgical center visit	$4[$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]	$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 **behavioral health** 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	$3	Full amount of the copayment

health center		
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) **Except for a foster care child,** a recipient shall not be exempt from paying the eight (8) dollar copayment for a nonpreferred brand name drug prescription.

(b) **No copayment shall be imposed for a service, prescription, item, supply, equipment, or any type of Medicaid benefit provided to a foster care child.**

(c) 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)**(a)[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) **shall apply regarding a service and a copayment obligation[~~; 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~~].

(b) Any amount of uncollected copayment by a provider from a recipient shall be considered a debt to the provider.

(6)**(a)** A provider:

1.[~~(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;

2.[~~(b)~~] Shall not waive a copayment[~~, coinsurance amount, or premium~~] obligation as imposed by the department for a recipient; and

3.[~~(c)~~] May collect a copayment[~~, coinsurance amount, or premium~~] at the time a benefit is provided or at a later date.

(b) Regarding a service or item for an enrollee in which the managed care organization in which the enrollee is enrolled does not impose a copayment, the provider shall not collect a copayment from the enrollee.

(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: March 28, 2014

FILED WITH LRC: March 31, 2014 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 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. The amendment after comments inserts a definition of "dependent child" and of "community spouse"; revises the definition of "preventive service"; clarifies that foster care children are exempt from all cost sharing; clarifies the copayment associated with behavioral health care to an "office visit for behavioral health care" rather than the initial terminology of "office visit for care by a behavioral health professional"; clarifies that KRS 205.6312(4) – a Kentucky Revised Statute which prohibits Medicaid providers from refusing to provide a service to a Medicaid recipient due to the recipient's inability to pay a copayment – is the relevant statutory requirement and deletes a reference to a related provision in the 2012-2013 Biennium Budget; clarifies that uncollected copayments by a provider shall be considered debt; and clarifies that a provider shall not collect a copayment from a Medicaid recipient enrolled in a managed care organization (MCO) if the MCO in which the recipient is enrolled imposes no copayment for the given service.

(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. The definitions added or revised via the amendment after comments are necessary for clarity; inserting language to exempt foster care children from copayments is necessary to correct an oversight; revising the behavioral health office visit language is necessary for clarity; eliminating the reference to the section of the Biennium Budget which [in contrast to KRS 205.6312(4)] allows pharmacist to deny prescriptions to a Medicaid recipient due to the recipient's not having the copayment is necessary as the Centers for Medicare and Medicaid Services (CMS) barred DMS (as a condition of approving the associated cost sharing "state plan amendment) from allowing a Medicaid provider to deny a service to a recipient due to the recipient not having the copayment for the service; clarifying that uncollected copayments equate to provider debt is necessary for clarity; and clarifying that a provider shall not collect a copayment from a Medicaid recipient enrolled in a managed care organization (MCO) if the MCO in which the recipient is enrolled imposes no copayment for the given service is necessary for clarity.

(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. The amendment after comments will conform to the authorizing statutes by clarifying policies and ensuring compliance with federal requirements.

(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. The amendment after comments will assist in the effective administration of the authorizing statutes by clarifying policies and ensuring compliance with federal requirements.

(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
(Amended After Comments)

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" **means an individual who is licensed as an optometrist in accordance with KRS Chapter 320[~~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 visions 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", **April 2014[~~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

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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 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. The amendment after comments replaces the material incorporated by reference – December 2013 version of the Department for Medicaid Services Vision Program Fee Schedule with the April 2014 version; revises the definition of "optometrist" to refer to the chapter of Kentucky Revised Statutes which govern the practice of optometry.

(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. Revising the Department for Medicaid Services Vision Program Fee Schedule is necessary as the prior version that was filed did not contain all of the vision codes covered by DMS. Amending the definition of "optometrist" is necessary for to refer to the appropriate chapter of Kentucky Revised Statutes.

(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. The amendment after comments conforms to the content of the authorizing statutes by incorporating a complete version of the Department for Medicaid Services Vision Program Fee Schedule and by referring to the appropriate chapter of Kentucky Revised Statutes for a definition of "optometrist."

(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. The amendment after comments assists in the effective administration of the authorizing statutes by incorporating a complete version of the Department for Medicaid Services Vision Program Fee Schedule and by referring to the appropriate chapter of Kentucky Revised Statutes for a definition of "optometrist."

(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. None were 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 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 Policy and Operations
(Amended After Comments)

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 Servicers 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) **"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.

(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9)[(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.

(10)[(9)] "Optometrist" **means an individual who is licensed as an optometrist in accordance with KRS Chapter 320[~~is defined by KRS 311.271~~]**.

(11)[(10)] "Provider" is defined by KRS 205.8451(7).

(12)[(11)] "Recipient" is defined by KRS 205.8451(9).

Section 2. General Requirements **and Conditions of Participation**. (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**; and**

(d) The confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.

(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)**(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.

(7)(a) A provider shall:

1. Have the freedom to choose whether to provide services to a recipient; and

2. 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 services 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.

(8) 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. **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. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 11. 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 **12.[~~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 **13.[~~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 **14.[~~11.~~]** Incorporation by Reference. (1) "Department for Medicaid Services Vision Program Fee Schedule", **April 2014[~~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: March 28, 2014

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CONTACT PERSON: Tricia Orme, email 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: The amendment after comments (in response to public comments) inserts basic Medicaid provider requirements that are stated in the physicians' program administrative regulation but were not stated in the prior version of this administrative regulation; replaces the material incorporated by reference – December 2013 version of the Department for Medicaid Services Vision Program Fee Schedule with the April 2014 version; and revises the definition of "optometrist" to refer to the chapter of Kentucky Revised Statutes which govern the practice of optometry.

(b) The necessity of the amendment to this administrative regulation: Inserting additional Medicaid provider basic provider requirements are necessary for protect integrity purposes and to help ensure recipient health, safety, and welfare; revising the Department for Medicaid Services Vision Program Fee Schedule is necessary as the prior version that was filed did not contain all of the vision codes covered by DMS; and amending the definition of "optometrist" is necessary for to refer to the appropriate chapter of Kentucky Revised Statutes.

(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 ensuring program integrity and recipient health, safety, and welfare; by incorporating a complete version of the Department for Medicaid Services Vision Program Fee Schedule; and by referring to the appropriate chapter of Kentucky Revised Statutes for a definition of "optometrist."

(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 ensuring program integrity and recipient health, safety, and welfare; by incorporating a complete version of the Department for Medicaid Services Vision Program Fee Schedule; and by referring to the appropriate chapter of Kentucky Revised Statutes for a definition of "optometrist."

(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 Provider Operations
(Amended After Comments)

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 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 **an arrangement through[~~a contractual partnership in~~]** which a physician assistant administers health care services under the**[~~employment and~~]** supervision of a physician **via a supervisory relationship that has been approved by the Kentucky Board of Medical Licensure**.

(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**:**

1. Pursuant to 907 KAR 1:677 **if the recipient is not an enrollee; or**

2. As established by the managed care organization in which the lock-in recipient is enrolled if the lock-in recipient is an enrollee.

(5) "Designated primary care provider" means the provider designated as a lock-in recipient's primary care provider**:**

1. Pursuant to 907 KAR 1:677 **if the recipient is not an enrollee; or**

2. As established by the managed care organization in which the lock-in recipient is enrolled if the lock-in recipient is an enrollee.

(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) A recipient enrolled in the lock-in program in accordance with 907 KAR 1:677**; or**

(b) An enrollee enrolled in a managed care organization's lock-in program pursuant to 907 KAR 17:020, Section 8.

(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, 0, 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.

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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 a physician's office shall not be covered as a separate reimbursable service through the physicians' 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;

(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)[~~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~~].

(6)[~~(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.

(7)[~~(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.

(8)[~~(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. [~~(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: March 28, 2014

FILED WITH LRC: March 31, 2014 at 3 p.m.

CONTACT PERSON: Tricia Orme, email 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. The amendment after comments re-inserts provisions regarding DMS's coverage of physician injectable drugs and related drugs in a physician's office; clarifies the definition of "common practice"; and also clarifies lock-in program provisions regarding managed care organizations. The lock-in program is a program in which individuals who are determined to excessively/inappropriately utilize services are locked in to using certain authorized providers.

(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 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. 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. The amendment after comments which re-inserts physician injectable drug and related provisions) is necessary as DMS continues to cover physician injectable and related drugs administered in a physician's office. The amendment after comments regarding lock-in programs and managed care organizations is necessary to clarify that managed care organizations do not have to employ the same lock-in program criteria used by DMS (pursuant to DMS's lock-in administrative regulation – 907 KAR 1:677.) Revising the definition of "common practice" is necessary for clarity.

(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. The amendment after comments conforms to the content of the authorizing statutes by clarifying policies.

(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. The amendment after comments assists in the effective administration of the authorizing statutes by clarifying policies.

(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
(Amended After Comments)

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. **(1)** The department shall reimburse for an occupational therapy service provided by an:

(a)[~~(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 **current** Kentucky-specific Medicare Physician Fee Schedule; or

(b)[~~(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 **current** Kentucky-specific Medicare Physician Fee Schedule.

(2)(a) The current Kentucky-specific Medicare Physician Fee Schedule shall be the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services on the date that the service is provided.

(b) For example, if an occupational therapy service is provided on a date when the Centers for Medicare and Medicaid Services':

1. Interim Kentucky-specific Medicare Physician Fee Schedule for a given year is in effect, the reimbursement for the service shall be the amount established on the interim Kentucky-specific Medicare Physician Fee Schedule for the year; or

2. Final Kentucky-specific Medicare Physician Fee Schedule for a given year is in effect, the reimbursement for the service shall be the amount established on the final Kentucky-specific Medicare Physician Fee Schedule for the year.

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: March 28, 2014

FILED WITH LRC: March 31, 2014 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: 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 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: The amendment after comments clarifies that DMS will use the version of the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services (CMS) at the time that the service is provided. CMS uses an interim fee schedule initially during a given year and then adopts a final version later in the year.

(b) The necessity of the amendment to this administrative regulation: The amendment after comments is necessary to clarify that DMS will use the current (whether interim or final for a given year) Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services.

(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 clarifying policy.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments assists in the effective administration of the authorizing statutes by clarifying policy.

(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
(Amended After Comments)

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. **(1)** The department shall reimburse for a physical therapy service provided by a:

(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 **current** Kentucky-specific Medicare Physician Fee Schedule; or

(b)[(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 **current** Kentucky-specific Medicare Physician Fee Schedule.

(2)(a) The current Kentucky-specific Medicare Physician Fee Schedule shall be the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services on the date that the service is provided.

(b) For example, if a physical therapy service is provided on a date when the Centers for Medicare and Medicaid Services':

1. Interim Kentucky-specific Medicare Physician Fee Schedule for a given year is in effect, the reimbursement for the service shall be the amount established on the interim Kentucky-specific Medicare Physician Fee Schedule for the year; or

2. Final Kentucky-specific Medicare Physician Fee Schedule for a given year is in effect, the reimbursement for the service shall be the amount established on the final Kentucky-specific Medicare Physician Fee Schedule for the year.

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: April 2, 2014

FILED WITH LRC: April 3, 2014 at 9 a.m.

CONTACT PERSON: Tricia Orme, email 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: The amendment after comments clarifies that DMS will use the version of the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services (CMS) at the time that the service is provided. CMS uses an interim fee schedule initially during a given year and then adopts a final version later in the year.

(b) The necessity of the amendment to this administrative regulation: The amendment after comments is necessary to clarify that DMS will use the current (whether interim or final for a given year) Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services.

(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 clarifying policy.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments assists in the effective administration of the authorizing statutes by clarifying policy.

(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
(Amended After Comments)

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. **(1)** 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 **current** Kentucky-specific Medicare Physician Fee Schedule.

(2)(a) The current Kentucky-specific Medicare Physician Fee Schedule shall be the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services on the date that the service is provided.

(b) For example, if a speech language pathology service is provided on a date when the Centers for Medicare and Medicaid Services':

1. Interim Kentucky-specific Medicare Physician Fee Schedule for a given year is in effect, the reimbursement for the service shall be the amount established on the interim Kentucky-specific Medicare Physician Fee Schedule for the year; or

2. Final Kentucky-specific Medicare Physician Fee Schedule for a given year is in effect, the reimbursement for the service shall be the amount established on the final Kentucky-specific Medicare Physician Fee Schedule for the year.

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: April 2, 2014

FILED WITH LRC: April 3, 2014 at 9 a.m.

CONTACT PERSON: Tricia Orme, email 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: The amendment after comments clarifies that DMS will use the version of the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services (CMS) at the time that the service is provided. CMS uses an interim fee schedule initially during a given year and then adopts a final version later in the year.

(b) The necessity of the amendment to this administrative regulation: The amendment after comments is necessary to clarify that DMS will use the current (whether interim or final for a given year) Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services.

(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 clarifying policy.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments assists in the effective administration of the authorizing statutes by clarifying policy.

(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
(Amended After Comments)

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) **"Advanced practice registered nurse" 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) "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.

(4)[~~"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.

(5)[(3)] "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.

(6)[(4)] "Emergency medical condition" is defined by 42 U.S.C. 1395dd(e)(1).

(7)[(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~~].

(8)[(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~~].

(9) "Individualized education program" is defined by 34 C.F.R. 300.320.

(10) "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(11) "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(12) "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(13) "Licensed professional counselor associate" is defined by KRS 335.500(3).

(14) "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.

(15) "Licensed psychological practitioner" means an individual who meets the requirements established in KRS 319.053.

(16) "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.

(17)[~~(7)~~] "Lock-in recipient" means**:**

(a) A recipient enrolled in the department's lock-in program pursuant to 907 KAR 1:677**; or**

(b) An enrollee enrolled in a managed care organization's lock-in program pursuant to 907 KAR 17:020, Section 8.

(18)[~~(8)~~] "Medical necessity" or "medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(19)[~~(9)~~] "Nonemergency" means that a condition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53.

(20)[~~(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~~].

(21)[~~(11)~~] "Recipient" is defined by KRS 205.8451(9).

(22)[~~(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 **who is**:

a. **Not an enrollee:**

(i) Provided by the lock-in recipient's designated hospital pursuant to 907 KAR 1:677; or

(ii)[~~b.~~] A screening or emergency service that meets the requirements of subsection (6)(a) of this section**; or**

b. An enrollee:

(i) Provided by the enrollee's designated hospital as established by the managed care organization in which the enrollee is enrolled; or

(ii) 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:

(a)[1.] In an emergency department of a hospital; or

(b)[2.] If provided by a hospital that is not the lock-in recipient's designated hospital**:**

1. Pursuant to 907 KAR 1:677 **if the recipient is not an enrollee**; or

2. As established by the managed care organization in which the lock-in recipient is enrolled if the lock-in recipient is an enrollee[~~(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) **Occupational therapy services shall be limited to twenty (20) service visits per calendar year per recipient.**

(4) 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~~].

(5)[(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. **Behavioral Health Services. (1) The following behavioral health services shall be covered:**

(a) Intensive outpatient program services;

(b) Partial hospitalization;

(c) Individual outpatient therapy; or

(d) Group outpatient therapy.

(2)(a) Intensive outpatient program services shall be provided by a team that includes 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;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor;

11. A certified social worker working under the supervision of a licensed clinical social worker;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist; or

13. A physician assistant working under the supervision of a physician.

(b) Intensive outpatient program services shall:

1. Be an alternative to inpatient hospitalization or partial hospitalization for a mental health or substance use disorder;

2. 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;

3. Be provided at least three (3) hours per day at least three (3) days per week; and

4. Include:

a. Individual outpatient therapy, group outpatient therapy, or family outpatient therapy unless contraindicated;

b. Crisis intervention; or

c. Psycho-education.

(c) During psycho-education the recipient or recipient's family member shall be:

1. 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

2. Taught how to cope with the recipient's diagnosis or condition in a successful manner.

(d) An intensive outpatient program services treatment plan shall:

1. Be individualized; and

2. Focus on stabilization and transition to a lesser level of care.

(e) To provide intensive outpatient program services, an outpatient hospital shall have:

1. Access to a board-certified or board-eligible psychiatrist for consultation;

2. Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;

3. Adequate staffing to ensure a minimum recipient-to-staff ratio of four (4) recipients to one (1) staff person;

4. The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;

5. The capacity to employ staff authorized to provide intensive outpatient program services in accordance with this section and to coordinate the provision of services among team members;

6. The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;

7. Demonstrated experience in serving individuals with behavioral health disorders;

8. The administrative capacity to ensure quality of services;

9. A financial management system that provides documentation of services and costs; and

10. The capacity to document and maintain individual case records.

(f) Intensive outpatient program services shall be provided in a setting with a minimum recipient-to-staff ratio of four (4) to one (1).

(3)(a) Partial hospitalization shall be 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;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor;

11. A certified social worker working under the supervision of a licensed clinical social worker;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist; or

13. A physician assistant working under the supervision of a physician.

(b) Partial hospitalization shall be a short-term (average of four (4) to six (6) weeks), less than twenty-four (24) hour, intensive treatment program for an individual who is experiencing significant impairment to daily functioning due to a substance use disorder, a mental health disorder, or co-occurring mental health and substance use disorders.

(c) Partial hospitalization may be provided to an adult or a child.

(d) Admission criteria for partial hospitalization shall be based on an inability to adequately treat the recipient through community-based therapies or intensive outpatient services.

(e) A partial hospitalization program shall consist of individual outpatient therapy, group outpatient therapy, family outpatient therapy, or medication management.

(f)1. The department shall not reimburse for educational, vocational, or job training services that may be provided as part of partial hospitalization.

2. An outpatient hospital's partial hospitalization program shall have an agreement with the local educational authority to come into the program to provide all educational components and instruction which are not Medicaid billable or reimbursable.

3. The department shall not reimburse for services identified in a Medicaid-eligible child's individualized education program.

(g) Partial hospitalization shall typically be:

1. Provided for a lesser number of hours per day and days per week than day treatment; and

2. Focused on one (1) primary presenting problem (i.e. substance use, sexual reactivity, etc.).

(h) An outpatient hospital's partial hospitalization program shall:

1. Include the following personnel for the purpose of providing medical care if necessary:

a. An advanced practice registered nurse;

b. A physician assistant or physician available on site; and

c. A board-certified or board-eligible psychiatrist available for consultation; and

2. Have the capacity to:

a. Provide services utilizing a recognized intervention protocol based on recovery principles;

b. Employ required practitioners and coordinate service provision among rendering practitioners; and

c. Provide the full range of services included in the scope of partial hospitalization established in this subsection.

(4)(a) Individual outpatient therapy shall be 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;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor;

11. A certified social worker working under the supervision of a licensed clinical social worker;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist; or

13. A physician assistant working under the supervision of a physician.

(b) 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.

(5)(a) Group outpatient therapy shall be 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;

10. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor;

11. A certified social worker working under the supervision of a licensed clinical social worker;

12. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist; or

13. A physician assistant working under the supervision of a physician.

(b)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.

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 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 **7.[~~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 **8.[~~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 **9.[~~8.~~]** Third Party Liability. A provider shall comply with KRS 205.622.

Section **10.[~~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 **11.[~~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 **12.[~~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 **13.[~~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: March 28, 2014

FILED WITH LRC: March 31, 2014 at 3 p.m.

CONTACT PERSON: Tricia Orme, email 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. The amendment after comments adds occupational therapy services to the scope of services covered in outpatient hospitals; clarifies the definition of "lock-in recipient" by establishing that the criteria for being in a managed care organization's lock-in program is as established in the relevant managed care organization administrative regulation (907 KAR 17:020, Section 8) rather than DMS's lock-in program administrative regulation (907 KAR 1:677); adds certain behavioral health services (intensive outpatient program services, partial hospitalization, individual outpatient therapy, and group outpatient therapy) to the scope of Medicaid coverage of outpatient hospital services; inserts definitions related to the behavioral health services; and adds other clarifying language regarding lock-in program provisions and managed care organizations.

(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 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. 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. The amendment after comments to include occupational therapy in the scope of covered outpatient hospital services is necessary to broaden the Medicaid occupational therapy provider base to help the Medicaid Program meet the recipient demand for services. The amendments regarding "lock-in" and managed care organizations are necessary to clarify that managed care organization's lock-in criteria (pursuant to 907 KAR 17:020, Section 8) may differ from DMS's provided that the managed care organization's criteria has been approved by DMS. Expanding the scope of outpatient hospital services to include certain behavioral health services is necessary to help meet Medicaid recipient demand for the services.

(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. The amendment after comments will conform to the content of the authorizing statutes by helping ensure Medicaid recipient access to care and by clarifying policy.

(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. The amendment after comments will assist in the effective administration of the authorizing statutes by helping ensure Medicaid recipient access to care and by clarifying policy.

(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. Occupational therapists and occupational therapy assistants will be affected by the amendment after comments.

(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. Medicaid recipients will benefit from occupational therapy being covered in the outpatient hospital setting and occupational therapists and occupational therapy assistants will benefit from being able to provide Medicaid-covered services in outpatient hospitals.

(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:

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amended After Comments)

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 **or supply** if the service **or supply** is:

(a) Provided:

1. By a:

a. Registered nurse employed by a:

(i) Private duty nursing agency that meets the requirements established in Section **1[3]** of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section **1[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 **1[3]** of this administrative regulation; or

(ii) Home health agency that meets the requirements established in Section **1[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: March 28, 2014
FILED WITH LRC: March 31, 2014 at 3 p.m.

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 primary 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 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 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: The amendment after comments eliminates the requirement that a home health agency must also be licensed pursuant to the Cabinet for Health and Family Services, Office of Inspector General's private duty nursing licensure administrative regulation (902 KAR 20:370) in order to provide private duty nursing services and clarifies that private duty nursing supplies are also covered in the scope of this administrative regulation.

(b) The necessity of the amendment to this administrative regulation: The amendment regarding home health agency requirements is necessary as DMS views the home health licensure requirements established in 902 KAR 20:081 as sufficient standards for a private duty nursing services provider and that preserving the requirement would be an unnecessary and duplicative burden placed on home health agencies. The clarification that supplies are covered is necessary for clarity.

(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 eliminating a duplicative burden on home health agencies and clarifying coverage.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments assists in the effective administration of the authorizing statutes by eliminating a duplicative burden on home health agencies and clarifying coverage.

(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. Any home health agency that is not enrolled with the Medicaid Program but wishes to provide Medicaid-covered private duty nurse services must likewise 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 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 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.

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
(Amended After Comments)

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" **or "APRN"** is defined by KRS 314.011(7).

(2) "Billing provider" means the individual **who** or **group of individual providers that**[~~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.

(5)[(6)] "Electronic signature" is defined by KRS 369.102(8).

(6)[(7)] "Enrollee" means a recipient who is enrolled with a managed care organization.

(7)[(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.

(8)[(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.

(9)[(10)] "Federal financial participation" is defined by 42 C.F.R. 400.203.

(10)[(11)] "Licensed clinical social worker" means an individual who meets the licensed clinical social worker requirements established in KRS 335.100.

(11)[(12)] "Licensed marriage and family therapist" is defined by KRS 335.300(2).

(12)[(13)] "Licensed professional clinical counselor" is defined by KRS 335.500(3).

(13)[(14)] "Licensed professional counselor associate" is defined by KRS 335.500(3).

(14)[(15)] "Licensed psychological associate" means an individual who:

(a)**1.** Currently possesses a licensed psychological associate license in accordance with KRS 319.010(6); and

2.[(b)] Meets the licensed psychological associate requirements established in 201 KAR Chapter 26**; or**

(b) Is a certified psychologist.

(15)[(16)] "Licensed psychological practitioner" means an individual who**:**

(a) Meets the requirements established in KRS 319.053**; or**

(b) Is a certified psychologist with autonomous functioning.

(16)[(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.

(17)[(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.

(18)[(19)] "Marriage and family therapy associate" is defined by KRS 335.300(3).

(19)[(20)] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(20)[(21)] "Peer support specialist" means an individual who meets the peer specialist qualifications established in 908 KAR 2:220.

(21) "Person-centered service plan" means a plan of services for a recipient that meets the requirements established in 42 C.F.R. 441.540.

(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) **"Provider group" means a group of more than one (1) individually licensed practitioners who form a business entity to:**

(a) Render health services; and

(b) Bill the Medicaid Program for services rendered to Medicaid recipients.

(27) "Qualified mental health professional" means an individual who meets the requirements established in KRS 202A.011(12).

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

(29)[(27)] "Recipient abuse" is defined by KRS 205.8451(10).

(30)[(28)] "Registered nurse" is defined by KRS 314.011(5).

(31)[(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: April 11, 2014

FILED WITH LRC: April 14, 2014 at 11 a.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: The amendment after comments deletes the definition of “community support associate”; clarifies that a “certified psychologist” is considered a “licensed psychological associate”; clarifies that a “certified psychologist with autonomous functioning” is considered a “licensed psychological practitioner”; and inserts a definition for “qualified mental health professional”, “provider group”, and “person-centered service plan.”

(b) The necessity of the amendment to this administrative regulation: Removing the definition of “community support associate” is necessary as services by these practitioners are not covered in the independent behavioral health provider setting. The other amendments are necessary for clarity.

(c) How the amendment conforms to the content of the authorizing statutes: The amendments after comments will conform to the content of the authorizing statutes by clarifying policies.

(d) How the amendment will assist in the effective administration of the statutes: The amendments after comments will assist in the effective administration of the authorizing statutes by clarifying policies.

(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:

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amended After Comments)

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; **and**

(c) Provided on a regularly scheduled basis except for a screening**,[or]** assessment**, or crisis intervention[; 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 Kentucky Medicaid Program in accordance with 907 KAR 1:671.

(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 **fee-for-service** 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 according 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 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;

(f) Individual outpatient therapy 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;

(g) Family outpatient therapy 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;

(h) Group outpatient therapy 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;

(i) Collateral outpatient therapy 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;

(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; **or**
3. An advanced practice registered nurse;

(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; **or**
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; **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;~~

~~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 **qualified** mental health professional; **or**
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 **qualified** 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 **qualified** mental health professional;

(p) Intensive outpatient program 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;

(q) Therapeutic rehabilitation program 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[~~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 **clinical[~~clinic~~]** disorder or service need;

3. **Include[~~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. **On-site at the provider's[~~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 **involve:**

a. Assisting a recipient in creating an individualized plan for services needed for maximum reduction of an intellectual disability; and

b. Restoring a recipient's functional level to the recipient's best possible functional level[~~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 **unless additional time is medically necessary**.

(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.

3. Family outpatient therapy shall:

a. Be provided to promote the:

(i) Health and wellbeing of the individual; or

(ii) Recovery from a substance related disorder; and

b. Not exceed three (3) hours per day per individual unless additional time is medically necessary.

(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 **per recipient unless additional time is medically necessary**.

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**; and**

c. Not exceed three (3) hours per day per individual unless additional time is medically necessary.

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[~~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 **except for methadone**; 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 **qualified mental health professional[~~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 **the** 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; **and**

c. Include:

(i) Reminding a recipient to take medications and monitoring symptoms and side effects of medications;**[~~or~~]**

(ii) Teaching parenting skills**;**

(iii)[~~,~~] Teaching community resource access and utilization**;**

(iv)[~~,~~] Teaching emotional regulation skills**;**

(v)[~~,~~] Teaching crisis coping skills**;**

(vi)[~~,~~] Teaching how to shop**;**

(vii)[~~,~~] Teaching about transportation**;**

(viii)[~~,~~] Teaching financial management**;**

(ix)[~~, or~~] Developing and enhancing interpersonal skills; **or**

(x) Improving daily living skills[~~and~~

~~c. Meet the requirements for comprehensive community support services established in 908 KAR 2:250~~].

2.[~~3.~~] To provide comprehensive community support services, a provider shall**:**

a. Have**[~~:~~**

~~a.~~] the capacity to employ staff authorized **pursuant to 908 KAR 2:250** 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; **and**

b. **Meet the requirements for comprehensive community support services established in 908 KAR 2:250[~~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 **employed by a provider group and who has experienced[~~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 **or 908 KAR 2:240**;

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 **or 908 KAR 2:240**; **and**

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**, who is employed by a provider group,** of a child who **has experienced[~~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; **and**

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~~].

(p)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;

c. Be provided at least three (3) hours per day at least three (3) days per week; and

d. Include:

(i) Individual outpatient therapy;

(ii) Group outpatient therapy;

(iii) Family outpatient therapy unless contraindicated;
(iv) Crisis intervention; or
(v) Psycho-education.
2. During psycho-education the recipient or recipient's 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 services 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, a provider shall:
a. Be employed by a provider group; and
b. Have:
(i) Access to a board-certified or board-eligible psychiatrist for consultation;
(ii) Access to a psychiatrist, other physician, or advanced practice registered nurse for medication management;
(iii) Adequate staffing to ensure a minimum recipient-to-staff ratio of fifteen (15) recipients to one (1) staff person;
(iv) The capacity to provide services utilizing a recognized intervention protocol based on recovery principles;
(v) The capacity to employ staff authorized to provide intensive outpatient program services in accordance with this section and to coordinate the provision of services among team members;
(vi) The capacity to provide the full range of intensive outpatient program services as stated in this paragraph;
(vii) Demonstrated experience in serving individuals with behavioral health disorders;
(viii) The administrative capacity to ensure quality of services;
(ix) A financial management system that provides documentation of services and costs; and
(x) The capacity to document and maintain individual case records.
5. Intensive outpatient program services shall be provided in a setting with a minimum recipient-to-staff ratio of fifteen (15) to one (1).
(g)1. A therapeutic rehabilitation program shall be:
a. A rehabilitative service for an:
(i) Adult with a serious mental illness; or
(ii) Individual under the age of twenty-one (21) years who has a serious emotional disability; and
b. Designed to maximize the reduction of an intellectual disability and the restoration of the individual's functional level to the individual's best possible functional level.
2. A recipient in a therapeutic rehabilitation program shall establish the recipient's own rehabilitation goals within the person-centered service plan.
3. A therapeutic rehabilitation program shall:
a. Be delivered using a variety of psychiatric rehabilitation techniques;
b. Focus on:
(i) Improving daily living skills;
(ii) Self-monitoring of symptoms and side effects;
(iii) Emotional regulation skills;
(iv) Crisis coping skill; and
(v) Interpersonal skills; and
c. Be delivered individually or in a group.

(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**; and[**~~,~~**]**

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the**:**

a. Cabinet for Health and Family Services upon request; **or**

b. Managed care organization in which the recipient is enrolled upon request if the recipient is enrolled with a managed care organization;

3. Made available for inspection and copying by**:**

a. Cabinet for Health and Family Services' personnel; **or**

b. Personnel of the managed care organization in which the recipient is enrolled if the recipient is enrolled with a managed care organization;

4. Readily accessible; **and**

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) **A provisional[**~~An appropriate~~**]** diagnosis;

(b) A referral for further consultation and disposition, if applicable; **or[**~~and~~**]**

(c)1. **If applicable,** termination of services and referral to an outside source for further services; or

2. **If applicable,** 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. **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[**~~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; **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.

(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 **within ten (10) business days of the transfer or referral**.

(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. **Be** treated as confidential;

2. Not be disclosed to an unauthorized individual; **and**

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 **auditing[~~Medicaid RAC Program~~]** purposes, the provider shall provide the **requested[~~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: April 11, 2014

FILED WITH LRC: April 14, 2014 at 11 a.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 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: The amendment after comments clarifies that crisis intervention does not have to be provided regularly; removes peer support specialists, family peer support specialists, and youth peer support specialists from the list of practitioners authorized to provide crisis intervention, day treatment, and comprehensive community support services; removes community support associates from the practitioners authorized to provide comprehensive community support services; adds intensive outpatient program as covered under this administrative regulation along with the associated requirements and provisions; adds therapeutic rehabilitation program as covered under this administrative regulation along with the associated requirements and provisions; adds therapeutic rehabilitation program; clarifies that individual outpatient therapy, group outpatient therapy, family outpatient therapy, and collateral outpatient therapy can be provided in excess of the three (3) hour per day limit if medically necessary; removes day treatment provisions that are not applicable; adds advanced practice registered nurses as practitioners authorize to provide medication assisted treatment for a substance use disorder; clarifies miscellaneous provisions; and corrects typographical or grammatical errors.

(b) The necessity of the amendment to this administrative regulation: The amendment after comments is necessary to clarify policies and to synchronize policies in the administrative regulation with what the federal government (Centers for Medicare and Medicaid Services or CMS) has approved.

(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 synchronizing policies in the administrative regulation with what CMS has approved and by clarifying policies.

(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 synchronizing policies in the administrative regulation with what CMS has approved and by clarifying policies.

(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
(Amended After Comments)

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; **or**

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;

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.

(9) The rate per unit for family 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;
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.

(10) The rate per unit for group 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;
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.

(11) The rate per unit for collateral 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;
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 **for a substance use disorder** 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; **or**
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; **or**

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 **qualified** mental health professional; **or**

(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 **qualified** 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 **qualified** mental health professional**[**~~**; or**~~

~~**(c) Youth peer support specialist working under the supervision of a mental health professional**~~]**.

(17) The rate per unit for an intensive outpatient program 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 under the supervision of a physician if the physician is the billing provider for the service.

(18) The rate per unit for a therapeutic rehabilitation program 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

2. 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 under the supervision of a physician if the physician is the billing provider for the service.

(19)(a) The department shall use the current version of the Kentucky-specific Medicare Physician Fee Schedule for reimbursement purposes.

(b) For example, if the Kentucky-specific Medicare Physician Fee Schedule currently published and used by the Centers for Medicare and Medicaid Services for the Medicare Program is:

1. An interim version, the department shall use the interim version until the final version has been published; or

2. Final version, the department shall use the final version.

(20) 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: April 11, 2014

FILED WITH LRC: April 14, 2014 at 11 a.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: The amendment after comments removes peer support specialists, family peer support specialists, and youth peer support specialists from practitioners authorized to provide crisis intervention services, day treatment, and comprehensive community support services; adds intensive outpatient program and therapeutic rehabilitation program as covered services; and clarifies that DMS will use the current version of the Kentucky-specific Medicare Physician Fee Schedule for reimbursement purposes. Thus, if CMS is currently using an interim fee schedule at a moment in time, DMS will use the interim fee schedule and if CMS publishes the final fee schedule (for the given year) then DMS will use the final version of the fee schedule at that time.

(b) The necessity of the amendment to this administrative regulation: Removing peer support specialists, family peer support specialists, and youth peer support specialists from authorized practitioners of crisis intervention services, day treatment, and comprehensive community support services is necessary as the Centers for Medicare and Medicaid Services (CMS) did not approve these practitioners for those services. Adding intensive outpatient program and therapeutic rehabilitation program as covered services is necessary as CMS did approve those services to be reimbursable in the independent behavioral health provider setting. The fee schedule amendment is necessary for clarity.

(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 synchronizing policies with those approved (and funded) by CMS and by clarifying policy.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments assists in the effective administration of the authorizing statutes by synchronizing policies with those approved (and funded) by CMS

and by clarifying policy.

(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? Reimbursements are tiered to the level of the provider/practitioner based on the provider/practitioner's education and experience.

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:

PROPOSED AMENDMENTS

EDUCATION PROFESSIONAL STANDARDS BOARD
(Amendment)

16 KAR 2:010. Kentucky teaching certificates.

RELATES TO: KRS 158.6451, 160.380, 161.020, 161.028(1), 161.030

STATUTORY AUTHORITY: KRS 161.028(1)(a), (b), (f), 161.030

NECESSITY, FUNCTION, AND CONFORMITY: KRS 161.028(1)(a) requires the Education Professional Standards Board to establish the standards for obtaining and maintaining a teaching certificate. KRS 161.028(1)(b) requires the board to set standards for programs for the preparation of teachers and other professional school personnel. KRS 161.028(1)(f) requires the board to issue and renew any certificate. This administrative regulation establishes the Kentucky certification to be issued for teaching positions.

Section 1. Definitions. (1) "Approved program of preparation" means a program which has been approved by the Education Professional Standards Board under 16 KAR 5:010 for a specific certification or which has been approved for certification by the state education agency of another state.

(2) "Assessments" means the tests of knowledge and skills authorized by KRS 161.030 and established in 16 KAR 6:010.

(3) "Base certificate" means a stand-alone license to teach which encompasses authorization to teach introductory and interdisciplinary courses in related fields.

(4) "Beginning teacher internship" means one (1) year of supervision, assistance, and assessment required by KRS 161.030 and established in 16 KAR 7:010.

(5) "Certificate endorsement" means an addition to a base or restricted base certificate, which is limited in scope and awarded on the basis of completion of an endorsement program or a combination of educational requirements, assessments, and experience as outlined in Section 5 of this administrative regulation.

(6) "Certificate extension" means an additional base or restricted base certificate in a content area or grade range.

(7) "Kentucky teacher standards" means the standards established in 16 KAR 1:010 that identify what a Kentucky teacher shall know and be able to do.

(8) "Major" means an academic area of concentration consisting of at least thirty (30) hours of coursework.

(9) "Professional teaching certificate" means the document issued to:

(a) An individual upon successful completion of the beginning teacher internship; or

(b) An applicant for whom the testing and internship requirement is waived under KRS 161.030 based on preparation and experience completed outside Kentucky.

(10) "Provisional teaching certificate" means the document issued to an individual for the duration of the beginning teacher internship program.

(11) "Restricted base certificate" means a stand-alone license to teach in a specific subject area of certification which is the only subject area that can be taught under this limited certificate.

(12) "Statement of eligibility" means the document issued to an applicant upon completion of an approved program of preparation and successful completion of the assessments.

Section 2. Certificate Issuance. (1)(a) Until December 31, 2014, a statement of eligibility for a provisional teaching certificate shall be issued to an applicant who has submitted a completed TC-1 application form and has successfully completed:

1.a.[(a)1.] At least a bachelor's degree with:

(i)[a.] A cumulative grade point average of 2.50 on a 4.0 scale; or

(ii)[b.] A grade point average of 3.00 on a 4.0 scale on the last sixty (60) hours of credit completed, including undergraduate and graduate coursework; or

b.[2.] As required by Section 4(2)(g)6 of this administrative regulation, a master's degree with:

(i)[a.] A cumulative grade point average of 2.50 on a 4.0 scale; or

(ii)[b.] A grade point average of 3.00 on a 4.0 scale on the last sixty (60) hours of credit completed, including undergraduate and graduate coursework;

2.[(b)] An approved program of preparation; and

3.[(c)] The assessments corresponding to the certificate identified in Section 4 of this administrative regulation for which application is being made.

(b) Beginning January 1, 2015, a statement of eligibility for a provisional teaching certificate shall be issued to an applicant who has submitted a completed CA-1 application form and has successfully completed:

1.a. At least a bachelor's degree with:

(i) A cumulative grade point average of 2.50 on a 4.0 scale; or

(ii) A grade point average of 3.00 on a 4.0 scale on the last sixty (60) hours of credit completed, including undergraduate and graduate coursework; or

b. As required by Section 4(2)(g)6 of this administrative regulation, a master's degree with:

(i) A cumulative grade point average of 2.50 on a 4.0 scale; or

(ii) A grade point average of 3.00 on a 4.0 scale on the last sixty (60) hours of credit completed, including undergraduate and graduate coursework;

2. An approved program of preparation;

3. The assessments corresponding to the certificate identified in Section 4 of this administrative regulation for which application is being made; and

4. A national and state criminal background check performed in accordance with KRS 160.380(5)(c) within twelve (12) months prior to the date of application.

(2) Upon confirmation of employment in an assignment for the grade level and specialization identified on a valid statement of eligibility, a Provisional Teaching Certificate shall be issued for the duration of the beginning teacher internship established under KRS 161.030.

(3) Upon successful completion of the internship, a Professional Teaching Certificate shall be issued, valid for a four (4) year period.

Section 3. Professional Teaching Certificate Renewal. (1) The renewal shall require completion of a fifth-year approved program of preparation which is consistent with:

(a) The Kentucky teacher standards established in 16 KAR 1:010; or

(b) The standards adopted by the Education Professional Standards Board for a particular professional education specialty and established in an applicable administrative regulation in KAR Title 16.

(2) The first five (5) year renewal shall require:

(a) Completion of a minimum of fifteen (15) semester hours of graduate credit applicable to the fifth-year approved program of preparation established in 16 KAR 8:020 by September 1 of the year of expiration of the certificate; or

(b) Completion of the required components of the continuing education option for initial certificate renewal as established in 16 KAR 8:030.

(3) The second five (5) year renewal shall require:

(a) Completion of the fifth-year approved program of preparation established in 16 KAR 8:020 by September 1 of the year of expiration of the certificate; or

(b) Successful completion of the continuing education option as established in 16 KAR 8:030.

(4) Each subsequent five (5) year renewal shall require completion of the renewal requirements established in 16 KAR 4:060.

Section 4. Grade Levels and Specializations. (1) Preparation

for a teaching certificate shall be based on:

(a) The Kentucky teacher standards established in 16 KAR 1:010;

(b) The accreditation and program approval standards established in 16 KAR 5:010, including the content standards of the relevant national specialty program associations; and

(c) The goals for the schools of the Commonwealth specified in KRS 158.6451 and the student academic expectations established in 703 KAR 4:060.

(2) A base certificate shall be issued specifying one (1) or more of the following grade level and specialization authorizations:

(a) Interdisciplinary early childhood education, birth to primary, established in 16 KAR 2:040;

(b) Elementary school: primary through grade 5 to include preparation in the academic disciplines taught in the elementary school.

1. The elementary certificate shall be valid for teaching grade 6 if grade 6 is taught in a self-contained classroom or in a school organization in which grade 6 is housed with grade 5 in the same building.

2. A candidate for the elementary certificate may simultaneously prepare for certification for teaching exceptional children.

(c)1. Middle school option 1: grades 5 through 9 with the equivalent of one (1) major to be selected from:

a. English and communications;

b. Mathematics;

c. Science; or

d. Social studies;

2. Middle school option 2: grades 5 through 9 with two (2) middle school teaching fields to be selected from:

a. English and communications;

b. Mathematics;

c. Science; or

d. Social studies;

3. The grades 5 through 9 mathematics certificate shall be valid for teaching Algebra I grades 10 and 11;

4. A candidate who chooses to simultaneously prepare for teaching in the middle school and for an additional base or restricted base certificate issued under this subsection or subsection (3) of this section, including certification for teaching exceptional children, shall be required to complete one (1) middle school teaching field;

(d) Secondary school: grades 8 through 12 with one (1) or more of the following majors:

1. English;

2. Mathematics;

3. Social studies;

4. Biology;

5. Chemistry;

6. Physics; or

7. Earth science;

(e) Grades 5 through 12 with one (1) or more of the following majors:

1. Agriculture;

2. Business and marketing education;

3. Family and consumer science;

4. Industrial education; or

5. Engineering and technology;

(f) All grade levels with one (1) or more of the following specialties:

1. Art;

2. A foreign language;

3. Health;

4. Physical education;

5. Integrated music;

6. Vocal music;

7. Instrumental music; or

8. School media librarian; or

(g) Grades primary through 12 for teaching exceptional children and for collaborating with teachers to design and deliver programs for preprimary children, for one (1) or more of the following disabilities:

1. Learning and behavior disorders;

2. Moderate and severe disabilities;

3. Hearing impaired;

4. Hearing impaired with sign proficiency;

5. Visually impaired;

6. Communication disorders, valid at all grade levels for the instruction of exceptional children and youth with communication disorders, which shall require a master's degree in communication or speech language pathology, in accordance with 16 KAR 2:050, Section 2; or

7. Communication disorders - SLPA only, valid at all grade levels for the instruction of exceptional children and youth with communication disorders, which shall require a baccalaureate degree in communication or speech language pathology, in accordance with 16 KAR 2:050, Section 3.

(3) A restricted base certificate shall be issued specifying one (1) or more of the following grade level and specialization authorizations:

(a) Psychology, grades 8-12;

(b) Sociology, grades 8 through 12;

(c) Journalism, grades 8 through 12;

(d) Speech/media communications, grades 8-12;

(e) Theater, primary through grade 12;

(f) Dance, primary through grade 12;

(g) Computer information systems, primary through grade 12; or

(h) English as a second language, primary through grade 12.

(4) An endorsement to certificates identified in subsection (2) or (3) of this section shall be issued specifying one (1) or more of the following grade level and specialization authorizations:

(a) Computer science, grades 8-12;

(b) English as second language, primary through grade 12;

(c) Gifted education, primary through grade 12;

(d) Driver education, grades 8-12;

(e) Literacy specialist, primary through grade 12;

(f) Reading, primary through grade 12;

(g) Instructional computer technology, primary through grade 12;

(h) Teacher Leader, all grades;

(i) Other instructional services - school safety, primary through grade 12;

(j) Other instructional services - environmental education, primary through grade 12;

(k) Other instructional services - elementary mathematics specialist, primary through grade 5;

(l) Learning and behavior disorders, grades 8 through 12. This endorsement shall be issued:

1. Following completion of the requirements of Section 5(2) of this administrative regulation; and

2. Only to candidates with preparation and certification for a base or restricted base certificate for the secondary grades 8-12; or

(m) American Sign Language, primary through grade 12.

Section 5. Additional Certification. (1) A certificate extension may be issued for any base or restricted base certificate area offered in Section 4(2) or (3) of this administrative regulation and shall require:

(a) A valid base or restricted base certificate, including a statement of eligibility;

(b) Successful completion of the applicable assessments; and

(c) Recommendation from an approved preparation program upon demonstration of competency in the relevant teaching methodology verified via coursework, field experience, portfolio, or other proficiency evaluation.

(2) A certificate endorsement may be issued for any area listed in Section 4(4) of this administrative regulation and shall require:

(a) A valid base or restricted base certificate, including a statement of eligibility;

(b) Successful completion of the applicable assessments; and

(c) Recommendation from an approved preparation program.

(3)(a) A professionally-certified teacher may add a certificate endorsement or extension if the teacher meets the requirements

established in paragraph (c)[~~(b)~~] of this subsection.

(b)1. Until December 31, 2014, an application for a certificate endorsement or extension shall be made on a Form TC-HQ.

2. Beginning January 1, 2015, an application for a certificate endorsement or extension shall be made on a Form CA-HQ.

(c) A certificate extension or certificate endorsement shall be issued if an educator[~~submits a completed TC-HQ application and~~]:

1. Holds a valid Kentucky professional teaching certificate;

2. Submits proof that the educator has:

a. Current employment in a certified position;

b. A bona fide offer of employment in a certified position in a Kentucky public school; or

c. Approval of the local district superintendent;

3. Successfully completed the applicable content assessments; and

4. Has either:

a. A declared major in the area of certification being sought; or

b. A combination of education, experience, professional development, awards and achievements in the area of certification being sought sufficient to demonstrate subject matter competency as evidenced by a score of ninety (90) points on the index contained within the application forms TC-HQ or CA-HQ[~~form, TC-HQ~~].

(i)[~~.~~] Points shall be granted only for experience, professional development, awards or achievements earned relative to the specific content area, student population taught, and grade range served.

(ii)[~~.~~] Coursework shall be validated on the application by a Kentucky college or university approved by the EPSB to serve as a "clearinghouse" for the purposes of this option.

(iii)[~~.~~] Successful completion of the appropriate content assessment or assessments for the certificate area being added shall count for forty-five (45) points.

(4) If a teacher currently holds a professional certificate in the secondary grades 8-12, and applies for a certificate extension or endorsement in the same content area for middle school grades 5-9, the teacher shall not be required to complete the content assessment.

(5) A certificate extension or endorsement issued under the requirements established in subsection (3)(b) of this section shall be permitted in the areas of English, mathematics, sciences, foreign languages, or social studies. Health and physical education areas shall be added only if the teacher holds the correlative certificate.

Section 6. A candidate pursuing certification via an alternative route to certification shall receive the same certificates delineated in Section 4 of this administrative regulation following completion of the appropriate requirements specific to each alternative route.

Section 7. (1) Until December 31, 2014, application for certification or additional certification shall be made on Form TC-1 and shall be accompanied by the fees required by 16 KAR 4:040.

(2) Beginning January 1, 2015, application for certification or additional certification shall be made on Form CA-1 and shall be accompanied by the fees required by 16 KAR 4:040.

Section 8. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Form CA-1", 03-14;

(b) "Form CA-HQ", 03-14;

(c) "Form TC-1", 10/05; and

(d)[~~(b)~~] "Form TC-HQ", 10/2009.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Education Professional Standards Board, 100 Airport Road, 3rd Floor, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

CASSANDRA WEBB, Chairperson

APPROVED BY AGENCY: March 17, 2014

FILED WITH LRC: April 8, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 30, 2014 at 9:00 a.m. at the offices of the Education Professional Standards Board, 100 Airport Road, 3rd Floor, Conference Room A, 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 close of business, June 2, 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: 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Alicia A. Sneed

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the Kentucky certification to be issued for teaching positions.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to provide notice to certification candidates of the requirements for obtaining and maintaining a teaching certificate.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 161.028(1)(a) requires the Education Professional Standards Board to establish standards and requirements for obtaining and maintaining a teaching certificate. KRS 161.028(1)(b) requires the board to set standards for programs for the preparation of teachers and other professional school personnel. KRS 161.028(1)(f) requires the board to issue and renew any certificate.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation lists the requirements for obtaining and maintaining a teaching certificate 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 replaces the current applications forms, TC-1 and TC-HQ, with the CA-1 and CA-HQ. Additionally, this amendment establishes a requirement that candidates for initial certification complete a national and state background check prior to applying for certification. All other amendments are made to clarify or correct the regulation.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure that the certification application process is collecting the appropriate data necessary to ensure that all Kentucky certified teachers are effective and have the appropriate disposition for the classroom.

(c) How the amendment conforms to the content of the authorizing statutes: The authorizing statues, KRS 161.020, 161.028, and 161.030, govern the certification of professional school personnel and grant the Education Professional Standards Board certification authority and the responsibility for establishing the requirements for obtaining and maintaining a certificate. This amendment establishes the requirements for obtaining and maintaining a teaching certificate.

(d) How the amendment will assist in the effective administration of the statutes: This amendment adopts an application form that will be easier for the applicant to understand and that will collect more concise information on the applicant. Additionally, the adoption of a criminal background check prior to certification will ensure that candidates have the appropriate

disposition for the classroom prior to applying for employment in Kentucky's public schools.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: 173 Kentucky school districts, thirty (30) educator preparation programs, and candidates for teacher certification.

(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 school districts will not be required to take any additional action. The educator preparation programs will need to advise candidates of the new application process and criminal background check requirement. Applicants will have to submit a criminal background check with their initial application for certification. Applicants will need to continue to refer to this regulation or the Education Professional Standards board website for current certification requirements.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Applicants for initial certification will have to bear the costs of a state and federal background check. Applicants that are prepared in Kentucky may not have any additional cost because they will have completed the required background check prior to student teaching. There will be no cost to the other entities identified in question (3).

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): All entities identified in question (3) will benefit from an up to date application process for certification that will ensure that applicants are properly screened for appropriate classroom dispositions.

(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: State General 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: This administrative regulation does require applicants for initial certificate to supply a state and federal background check. In an attempt to lessen the potential financial burden on applicants, the state and federal background check required will be the same as statutorily required for student teaching or employment as a certified educator in Kentucky's public schools.

(9) TIERING: Is tiering applied? Yes, applicants for initial certification will be required to submit a state and federal background check with their application. This will allow the Education Professional Standards Board to conduct an in-depth screening of applicants prior to granting initial certification.

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 Education Professional Standards Board, 173 school districts, 8 public universities with educator preparation programs.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 161.028

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 should be 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? This is not a revenue generating 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? This is not a revenue generating regulation.

(c) How much will it cost to administer this program for the first year? There may be a minimal cost to the Education Professional Standards Board to update its website and ensure that applicants use the new form required by this amendment.

(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 (+/-): None

Expenditures (+/-): None

Other Explanation: This regulatory amendment adopts a new form and requires the applicant to submit additional information to ensure he or she is properly reviewed prior to receiving certification.

EDUCATION PROFESSIONAL STANDARDS BOARD
(Amendment)

16 KAR 4:060. Certificate renewals and[~~successful~~] teaching experience.

RELATES TO: KRS 161.020, 161.028, 161.030

STATUTORY AUTHORITY: KRS 161.028, 161.030

NECESSITY, FUNCTION, AND CONFORMITY: KRS 161.020, 161.028, and 161.030 require that a teacher and other professional school personnel hold a certificate of legal qualification for his or her respective position to be issued upon completion of a program of preparation prescribed by the Education Professional Standards Board. KRS 161.020 provides that the validity and terms for the renewal of a certificate shall be determined by the laws and administrative regulations in effect at the time the certificate was issued. This administrative regulation establishes certificate renewal provisions and the requirements for successful teaching experience for certificate issuance and renewal.

Section 1. Certificate Renewals. (1) If the renewal of a teaching certificate requires the completion of additional academic course work in lieu of teaching experience, the credits shall be selected from the Planned Fifth-Year Program.

(2) Except as provided in KRS 161.030(3), a teaching certificate shall be issued for a duration period of five (5) years, with provision for subsequent five (5) year renewals.

(3)(a) A certificate shall be renewed for subsequent five (5) year periods upon the completion of:

1. Three (3) years of successful teaching experience as established in Section 2 of this administrative regulation; or

2. At least six (6) semester hours of credit or the equivalent in professional development defined in 16 KAR 8:020.

(b) The requirements of this subsection shall apply to teachers who have completed the Fifth Year Program renewal requirements established in 16 KAR 8:020 and 16 KAR 2:010, Section 3.

(4) The renewal requirements shall be completed by September 1 of the year of expiration of the certificate.

(5)(a) Upon expiration, a regular certificate shall be extended for one (1) time for the one (1) year period immediately following the expiration date if:

1.a. Until December 31, 2014, an application for the extension is submitted using Form TC-2; or

b. Beginning January 1, 2015, an application for the extension is submitted using Form CA-2;

2. The certificate holder has completed at least one-third (1/3)

of the renewal requirements; and

3. The extension is recommended by the employing school superintendent.

(b) If the requirements of paragraph (a) of this subsection are met, the remainder of the renewal requirements shall be completed within the one (1) year period of reinstatement.

(6)(a) Experience in the armed forces of the United States of America shall be accepted toward the renewal of a teaching certificate in lieu of required teaching experience as established in Section 2 of this administrative regulation, if the applicant held a valid certificate prior to entering military service.

(b) The validity period of a certificate held by a person at the time of entry into the armed forces of the United States of America shall be extended for the same period of time for which it was valid at the time of entry, beginning from the date of discharge.

(7) For a certificate requiring teaching experience for renewal, experience as a substitute teacher shall be accepted in lieu of required teaching experience as established in Section 2 of this administrative regulation if the holder of the certificate:

(a) Was employed officially by the local board of education;

(b) Was paid through the board of education; and

(c) Substituted in his certification area no less than thirty (30) teaching days per semester.

(8) Work experience at the Education Professional Standards Board, Kentucky Department of Education, or other state or federal educational agency with oversight for elementary and secondary education shall be accepted toward the renewal of a teaching certificate in lieu of teaching experience as established in Section 2 of this administrative regulation.

(9) Teaching experience at a regionally- or nationally-accredited institution of higher education in the academic subject area for which the teacher holds certification shall be accepted toward the renewal of a teaching certificate in lieu of teaching experience as established in Section 2 of this administrative regulation.

(10)(a) Until December 31, 2014, application for certification renewal shall be made on Form TC-2.

(b) Beginning January 1, 2015, application for certification renewal shall be made on Form CA-2.

Section 2.[~~Successful~~] Teaching Experience for Certificate Issuance and Renewal. (1)[~~Successful~~] Teaching experience shall be in a position directly corresponding to the type of teaching certificate for which the application is being made.

(2) A full year of experience shall include at least 140 teaching days of employment performed within the academic year.

(3) A half year of experience shall include at least seventy (70) teaching days of employment performed within an academic semester.

(4) The experience shall include employment on at least a half-time basis as defined in 16 KAR 7:010.

(5) The experience may include employment in either a public school or a regionally- or nationally-accredited nonpublic school.

(6) Experience as a home school teacher shall not be accepted as successful teaching experience.

(7)(a) Until December 31, 2014, the superintendent of the employing district or chief school officer of the employing nonpublic school shall verify[~~successful~~] teaching experience on the certification application, Form TC-1, which is incorporated by reference in 16 KAR 2:010, for initial certification or Form TC-2 for certificate renewal.

(b) Beginning January 1, 2015, the superintendent of the employing district or chief school officer of the employing nonpublic school shall verify teaching experience on the Form CA-1, which is incorporated by reference in 16 KAR 2:010, for initial certification or Form CA-2 for certificate renewal.

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

(a) "Form CA-2", 03/2014; and

(b) "Form TC-2", rev. 10/03[~~, is incorporated by reference~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Education Professional Standards Board, 100 Airport Road, 3rd Floor, Frankfort, Kentucky 40602, Monday through Friday, 8 a.m. to 4:30 p.m.

CASSANDRA WEBB, Chairperson

APPROVED BY AGENCY: March 17, 2014

FILED WITH LRC: April 8, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 30, 2014 at 9:00 a.m. at the offices of the Education Professional Standards Board, 100 Airport Road, 3rd Floor, Conference Room A, 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 close of business, June 2, 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: 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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Alicia A. Sneed

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes certificate renewal provisions and the requirements for successful teaching experience for certificate issuance and renewal.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to provide notice to certification candidates of the requirements for obtaining and maintaining a teaching certificate.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 161.020, 161.028, and 161.030 require that a teacher and other professional school personnel hold a certificate of legal qualification for his or her respective position to be issued upon completion of a program of preparation prescribed by the Education Professional Standards Board. KRS 161.120 provides that the validity and terms for the renewal of a certificate shall be determined by the laws and administrative regulations in effect at the time certificate was issued.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation lists the requirements for renewing a certificate 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 incorporates the CA-2 form. This amendment also removes the term "successful" from the requirements for three years of teaching experience for certificate renewal. The term "successful" was not defined in the regulation and was interpreted subjectively by employing superintendents. In order to remove subjectivity from the certification renewal process, the word "successful" will be deleted until an objective and statewide standard can be developed.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure that the most recent application forms are used and that all applicants for certification renewal are treated equally.

(c) How the amendment conforms to the content of the authorizing statutes: The authorizing statues, KRS 161.020, 161.028, and 161.030, govern the certification of professional

school personnel and grant the Education Professional Standards Board certification authority and the responsibility for establishing the requirements for obtaining and maintaining a certificate. This amendment establishes certificate renewal provisions and the requirements for certificate renewal.

(d) How the amendment will assist in the effective administration of the statutes: This amendment ensures that the certification application is the most current one available.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: 173 Kentucky school districts, thirty (30) educator preparation programs, and candidates for teacher certification.

(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 school districts will not be required to take any additional action. The educator preparation programs will not need to take any additional action. Applicants will need to continue to refer to this regulation or the Education Professional Standards board website for current certification requirements.

(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 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): All entities will be using the most recent certification forms, ensuring consistency in the application process.

(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: State General 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: This administrative regulation does not establish any fees, or directly or indirectly increase fees.

(9) TIERING: Is tiering applied? No, tiering does not apply since all candidates for certification will be held to the same 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 Education Professional Standards Board, 173 school districts, and eight (8) public universities with educator preparation programs.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 161.028

(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 should be 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? This is not a revenue generating 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? This is not a revenue generating regulation.

(c) How much will it cost to administer this program for the first year? There may be a minimal cost to the Education Professional Standards Board to update its Web site and ensure that applicants use the new form required by this amendment.

(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 (+/-): None

Expenditures (+/-): None

Other Explanation: This regulatory amendment adopts a new form and requires the applicant to submit additional information to ensure he or she is properly reviewed prior to receiving certification.

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

103 KAR 43:330. Measurement of compressed natural gas (CNG) and liquefied natural gas (LNG) in gallons.

RELATES TO: KRS 138.210, 138.220, 138.250

STATUTORY AUTHORITY: KRS 131.130(1), 138.226(1), 138.250

NECESSITY, FUNCTION AND CONFORMITY: KRS 131.130(1) authorizes the Department of Revenue to promulgate administrative regulations for the administration of all tax laws. KRS 138.226(1) authorizes the department to promulgate administrative regulations necessary to administer gasoline and special fuel taxes. This administrative regulation prescribes the method of measurement of compressed natural gas and liquefied natural gas in gallons as a special fuel.

Section 1. Definitions. (1) "Compressed natural gas" means natural gas compressed into high pressure fuel cylinders capable of being used to operate or propel any vehicle on public roadways.

(2) "Special fuels" is defined in KRS 138.210(4)(b) and includes compressed natural gas and liquefied natural gas.

(3) "Liquefied natural gas" means natural gas that has been converted to liquid form for ease of storage or transport.

Section 2. Conversion Method. (1) For purposes of reporting the number of gallons subject to the tax imposed by KRS 138.220 as required by KRS 138.250, every special fuels dealer[~~who manufactures compressed natural gas~~] shall convert compressed natural gas or liquefied natural gas into[~~the quantity produced from pounds to~~] gallons.

(2) The conversion rate used shall be 5.66 pounds or 126.67 cubic feet of compressed natural gas to one (1) gallon of special fuels.

(3) The conversion rate used shall be 6.06 pounds or 1.52 gallons of liquefied natural gas to one (1) gallon of special fuels.

Section 3. (1) This administrative regulation shall replace Revenue Policy 72P105.

(2) Revenue Policy 72P105 is hereby rescinded and shall be null, void, and unenforceable.

THOMAS B. MILLER, Commissioner

APPROVED BY AGENCY: April 8, 2014

FILED WITH LRC: April 14, 2014 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 27, 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 at least five (5) workdays prior to the hearing, of their intent to attend.

If no notification of intent to attend the hearing is received by the required 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 this proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business June 2, 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: Lisa Swiger, Department of Revenue, 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: Gives licensed dealers a standardized conversion measurement on alternative fuels for a diesel gallon equivalent.

(b) The necessity of this administrative regulation: Compressed Natural Gas (CNG) and Liquefied Natural Gas (LNG) are now alternative fuels used in motorized vehicles. They are usually measured in pounds, cubic feet, or an LNG gallon. Industry needs the conversion factors to meet the statutory requirement that they be taxed in gallons at a comparable rate to special fuels.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 131.130(1) authorizes the Department of Revenue to promulgate administrative regulations for the administration and enforcement of all tax laws. The proposed amendment updates the regulation to industry changes and provides the conversion factors to use for the tax computation.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation standardizes the conversion factors to use when converting CNG and LNG measurement units to a taxable gallon.

(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 expands the regulation for CNG to cover the fuel when using a different unit of measurement for gallon conversion. It is also being expanded to address the conversion factor for LNG which is moving into the State.

(b) The necessity of the amendment to this administrative regulation: To provide licensed dealers standardized conversion factors for reporting and paying the motor fuel tax on alternative fuels.

(c) How the amendment conforms to the content of the authorizing statutes: The statute states the tax is based on gallons. Dealers need to know the conversion factors to report these alternative fuels in gallons equivalent to diesel fuel.

(d) How the amendment will assist in the effective administration of the statutes: By putting the conversion factors in the regulation, it provides licensed dealers a consistent and definitive way to convert these products into measurements equivalent to diesel gallons.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Markets for both CNG and LNG are just emerging. A few municipalities and waste management operations currently use CNG in this state. The transportation industry and alternative fuel dealers are beginning to invest in the LNG infrastructure for rollout in Kentucky. This proposed amendment provides guidance to facilitate these emerging markets.

(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 entities will use the conversion factors specified for fuel reporting purposes.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Nothing additional.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Gives guidance to licensed dealers on what factors to use to convert the product into taxable gallons

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

(a) Initially- No new costs will be incurred beyond routine regulatory promulgation which the department already carries out.

(b) On a continuing basis: No new costs will be incurred beyond our normal administration of motor fuels taxes.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation? Current department budgetary 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 new fees will be necessary to implement this amendment.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No fees are established or increased.

(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? Only those which plan to deal in the sale or resale of CNG or LNG.

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. 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? This amendment provides a conversion factor for calculation of taxable gallons of fuel. It does not generate additional revenue but assists in preserving tax receipts when fuel in alternative forms is utilized.

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

(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:

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(Amendment)

201 KAR 9:305. Continued licensure[~~certification~~] of athletic trainers.

RELATES TO: KRS 214.610(1), 311.901(1), 311.905(2), 311.909(1)(o)[~~311.900-311.928~~]
STATUTORY AUTHORITY: KRS 311.901(1)[~~311.908(1), (4)~~]
NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.901(1) requires the Kentucky Board of Medical Licensure to promulgate administrative regulations relating to the licensure and regulation of athletic trainers and requires continuing education courses on the transmission, control, treatment, and prevention of the human immunodeficiency virus and acquired immunodeficiency syndrome.[~~311.908(1) empowers the State Board of Medical Licensure to adopt rules and administrative regulations as necessary to fulfill their statutory duty and obligation to certify qualified athletic trainers to practice within the Commonwealth of Kentucky. The purpose of~~] This administrative regulation establishes[~~is to establish~~] the criteria for the continued licensure[~~certification~~] of athletic trainers.

Section 1. Definition. "CEU"[~~Definitions. "Continuing education unit (CEU)"~~] means the completion of ten (10) hours of educational courses approved by the:
(1) Kentucky Board of Medical Licensure; or
(2) Board of Certification, Inc[~~National Athletic Trainer Association (NATA)~~].

Section 2. (1) An athletic trainer licensed[~~certified~~] to practice in the Commonwealth of Kentucky shall complete six (6) CEUs during each three (3) year renewal cycle beginning with the renewal cycle that ends on June 30, 2015[~~:~~
~~(a) For the three (3) year period, July 1, 1991 - June 30, 1994; and~~
~~(b) For each three (3) year period thereafter~~].
(2) During each ten (10) year period of practice, each licensee shall complete a minimum of two (2) hours of continuing education in HIV/AIDS courses approved pursuant to KRS 214.610, 214.615 and 214.620[~~In each three (3) year period, the required CEUs shall include the human immunodeficiency virus and acquired immune deficiency syndrome educational course approved by the Cabinet for Human Resources in 902 KAR 2:150~~].

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: March 31, 2014
FILED WITH LRC: April 9, 2014 at 11 a.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 28, 2014 at 10:00 a.m. at the offices of the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Individuals interested in being heard at this hearing shall notify this agency in writing by May 20, 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 the close of business on June 2, 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: Leanne K. Diakov, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Leanne K. Diakov
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the criteria for the continued licensure of athletic trainers.
(b) The necessity of this administrative regulation: It is necessary to promulgate this regulation to establish the criteria for the continued licensure of athletic trainers.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation acts specifically to establish the criteria for the continued licensure of athletic trainers.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation acts specifically to establish the criteria for the continued licensure of athletic trainers.
(2) If this is an amendment to an existing regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment changes certification of athletic trainers to licensure of athletic trainers.
(b) The necessity of the amendment to this administrative regulation: It is necessary to promulgate this regulation to change certification of athletic trainers to licensure of athletic trainers.
(c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation acts specifically to change certification of athletic trainers to licensure of athletic trainers.
(d) How the amendment will assist in the effective administration of the statutes: This amendment acts specifically to change certification of athletic trainers to licensure of athletic trainers.
(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This amendment will affect all athletic trainers licensed in the Commonwealth of Kentucky.
(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 this administrative regulation or amendment: Athletic trainers will now be licensed instead of certified. No required action on the part of athletic trainers.
(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): Athletic trainers will now receive a license instead of a certificate.
(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 funding to be used for the implementation and enforcement of this administration regulation: None.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase of fees or funding will be necessary.
(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 appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals 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 Kentucky Board of Medical Licensure 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 311.901(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. 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? None

(d) How much will it cost to administer this program for subsequent years? None

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(Amendment)

201 KAR 9:307. Fee schedule regarding athletic trainers.

RELATES TO: KRS 311.901(1), 311.905(1)(a), (3)

STATUTORY AUTHORITY: KRS 311.901(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.901(1) requires the Kentucky Board of Medical Licensure[~~authorizes the board~~] to promulgate administrative regulations necessary to establish fees relating to the licensure[~~certification~~] and regulation of athletic trainers. This administrative regulation establishes a schedule of fees for services rendered by the board.

Section 1. Fee Schedule for Athletic Trainers. (1) Fee for initial issuance of regular license[~~certificate~~] - $100.

(2) Fee for renewal of license[~~certificate~~], three (3) year period - fifty (50) dollars.

(3) Fee for activation of an inactive license[~~certificate~~] - fifty (50) dollars.

(4) Issuance of duplicate wallet card – five (5) dollars[~~one (1) dollar~~].

(5) Issuance of duplicate wall license[~~certificate~~] - ten (10) dollars.

(6) Verification of state license[~~certificate~~] to another licensing agency - ten (10) dollars.

PRESTON P. NUNNELLEY, M.D., President

APPROVED BY AGENCY: March 31, 2014

FILED WITH LRC: April 9, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 28, 2014 at 10:00 a.m. at the offices of the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Individuals interested in being heard at this hearing shall notify this agency in writing by May 20, 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 the close of business on June 2, 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: Leanne K. Diakov, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Leanne K. Diakov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes a schedule of fees for services rendered by the Board.

(b) The necessity of this administrative regulation: It is necessary to promulgate this regulation to establish a schedule of fees for services rendered by the board.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation acts specifically to establish a schedule of fees for services rendered by the board.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation acts specifically to establish a schedule of fees for services rendered by the board.

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

(a) How the amendment will change this existing administrative regulation: This amendment changes certificate to license. It also changes the fee for issuance of a duplicate wallet card to five (5) dollars.

(b) The necessity of the amendment to this administrative regulation: It is necessary to promulgate this regulation to change certificate to license and to change the fee for the issuance of a duplicate wallet card to five (5) dollars.

(c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation acts specifically to establish a schedule of fees for services rendered by the Board. It also changes the fee for the issuance of a duplicate wallet card to five (5) dollars.

(d) How the amendment will assist in the effective administration of the statutes. This amendment acts specifically to change certificate to license. It also changes the fee for the issuance of a duplicate wallet card to five (5) dollars.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This amendment will affect all athletic trainers licensed in the Commonwealth of Kentucky.

(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 this administrative regulation or amendment: Athletic trainers will now be licensed instead of certified. No required action on the part of athletic trainers.

(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): Athletic trainers will not receive a license instead of a certificate.

(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 funding to be used for the implementation and enforcement of this administration regulation: None.
(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase of fees or funding will be necessary.
(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation does increase the fee for the issuance of a duplicate wallet card to five (5) dollars.
(9) TIERING: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals 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 Kentucky Board of Medical Licensure 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 311.901(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. 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? None
(d) How much will it cost to administer this program for subsequent years? None
Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-):
Expenditures (+/-):
Other Explanation:

GENERAL GOVERNMENT
Kentucky State Board of Licensure for Professional Engineers and Land Surveyors
(Amendment)

201 KAR 18:192. Continuing professional development for professional land surveyors.

RELATES TO: KRS 322.180(3), 322.190, 322.270, 322.290(15)
STATUTORY AUTHORITY: KRS 322.290(4), (15)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 322.290(15) requires the board to adopt a program of continuing education for professional land surveyors. This administrative regulation implements the continuing professional development program mandated by KRS 322.290(15) for professional land surveyors.

Section 1. Definitions. (1) "Completion" means the professional land surveyor has satisfactorily met specific requirements of an offering by taking and passing a university course or attending a seminar.

(2) "Continuing professional development" or "CPD" means participation in activities, beyond the basic educational requirements, that:
(a) Provide specific content planned and evaluated to improve the land surveyor's professional competence;
(b) Encourage acquisition of new skills and knowledge required to maintain competence;
(c) Strengthen the professional land surveyor's critical inquiry and balanced judgment;
(d) Raise the ethical standards within the professional community; and
(e) Meet the requirements established by this administrative regulation.
(3) "CPDC" means the Continuing Professional Development Committee.
(4) "Professional development hour" or "PDH" means not less than fifty (50) minutes of instruction or presentation that meets the requirements of this administrative regulation.
(5) "Provider" means a person, school, association, company, corporation, or group who has developed a CPD activity and participates directly in the presentation.
(6) "Sponsor" means a group, organization, or professional society, offering activities by providers.

Section 2. Continuing Professional Development Committee. (1) The chair of the State Board of Licensure for Professional Engineers and Land Surveyors shall appoint a Continuing Professional Development Committee and name its chair.
(2) The CPDC shall consist of five (5)[~~three (3)~~] board of licensure members of which at least three (3)[~~two (2)~~] are professional land surveyors.
(3) Work of the CPDC shall be considered work of the board and compensation shall be given as provided by KRS 322.270.
(4) The CPDC shall hold regular meetings and a record of its action shall be maintained.
(5) The CPDC may rule on all matters concerning continuing professional development for professional land surveyors. Decisions of the CPDC shall be ratified by the board. A licensee who disagrees with a decision of the CPDC may direct his or her concerns to the board for consideration at a subsequent meeting of the board.

Section 3. Program Structure. (1) Except as provided by Sections 3(3), 6(1), and 6(2) of this administrative regulation, a professional land surveyor shall complete and report to the board a minimum of eight (8) professional development hours for each calendar year, for a total of a minimum of sixteen (16) professional development hours for each reporting period.
(2) The requirement for professional development hours shall include a four (4) hour[~~board sponsored~~] course, pre-approved by the CPDC, in standards of practice for professional land surveyors, professional ethics, and the code of professional practice and conduct, taken once every four (4) years. In the year that this course is taken, it shall count as four (4) of the required eight (8) hours.
(3) A maximum of four (4) hours in excess of the sixteen (16) professional development hours required to be earned in a reporting period may be carried forward to the next reporting period.
(4) Failure to earn the sixteen (16) professional development hours per reporting period shall make the licensee ineligible for licensure renewal.

Section 4. Criteria for Professional Development. (1) Professional development hours may be earned by successful completion of the following activities subject to approval by the CPDC and board:
(a) College or university courses;
(b) Seminars;
(c) Tutorials;
(d) In-house programs sponsored by corporations or other organizations;
(e) Correspondence courses;

(f) Televised or videotaped courses;

(g) Distance learning courses;

(h) Teaching or instructing courses, programs, or items specified in paragraphs (a) through (g) of this subsection; this credit may be claimed at twice the number of hours permitted participants, except the credit shall not be claimed more than once for teaching or instructing the same or substantially similar course, program, or item;

(i) Making or attending approved presentations at technical or professional meetings; or

(j) Publication of papers, articles, or books related to the practice of land surveying.

(2) Activities described in subsection (1) of this section shall:

(a) Be relevant to the practice of land surveying;

(b) Contain technical, ethical, or managerial subjects;

(c) Be an organized program of learning;

(d) Be conducted by individuals with education, training, or expertise;

(e) Be offered for the number of professional development hours recommended by the program author, subject however, to review, and acceptance or adjustment, by the CPDC; and

(f) Not include in-service training, orientation to specific institutional policies and practices, or time used to sell or advertise a product.

(3) CPD activities shall earn credit only if substantially different from a course for which credit was claimed or granted in the current calendar year or previous two (2) calendar years.

(4) Professional development hours shall be converted as follows:

(a) One (1) university semester hour shall equal fifteen (15) professional development hours.

(b) One (1) university quarter hour shall equal ten (10) professional development hours.

(c) One (1) continuing education unit shall equal ten (10) professional development hours.

Section 5. Approval of a Continuing Professional Development Activity. Activity approvals may be granted for sponsors, providers, or individual professional land surveyors as follows:

(1) Approval of activities is valid for a specified approval period or until alteration of the activity is approved by the CPDC.

(2) Failure to notify the CPDC of a change in an activity, including a change in the instructor, may render approval of the activity null and void.

(3) Prior to approval, an activity shall not be advertised as approved for Kentucky professional land surveyors but may be advertised that the activity has been "submitted for consideration."

(4) If prior or post approval is desired, a written request for approval of the activity shall be submitted to and received by the CPDC on the Continuing Professional Development Course Approval Form at least forty-five (45) days prior to the meeting date of the CPDC at which the request will be considered.

(5) All requests for approval of an activity shall be accompanied by:

(a) A detailed outline and objectives;

(b) A time outline including registration, introductions, welcomes, breaks, and meals;

(c) Handouts or reference materials needed to evaluate the activity; and

(d) A resume for each instructor or speaker in the activity.

(6) The CPDC or board reserves the right to send a representative to monitor an activity:

(a) The provider or sponsor shall waive all fees for the CPDC or board representative; and

(b) Approval for the activity may be withdrawn for subsequent iterations of the activity, if significant variation is observed from the approved activity.

(7) An evaluation form shall be made available for participants at each presentation.

(8) An individual under disciplinary action from the board or a business entity with a principal who is under disciplinary action from the board shall not present a CPD activity for credit without prior, written approval from the board.

(9) If a provider fails to obtain prior approval, a professional land surveyor may request credit for an activity by making a written request for post approval to the CPDC and including in that request, the items listed in subsection (5) of this section.

(10) Upon approval, an activity shall receive a CPD number which shall be used to identify the activity.

(11) If an activity is not approved by the CPDC, the requestor shall be sent notice of nonapproval within two (2) weeks of its decision. This decision shall be presented to the board at its next meeting for ratification.

Section 6. Exemptions and Extensions. The following professional land surveyors may be exempted from the requirements of this administrative regulation by submitting a written request to the CPDC with supporting documentation for the exemption:

(1) A professional land surveyor shall be exempted for the reporting period containing the calendar year in which he or she is initially licensed by the board.

(2) A professional land surveyor who cannot satisfy the CPD requirement because of physical disability, illness, or other extenuating circumstance may be exempted for the calendar year in which the disability, illness, or extenuating circumstance occurs. The CPDC may grant an extension of time to fulfill the yearly CPD requirement for an extenuating circumstance.

(3) An exemption or extension request shall be made in writing for each calendar year and the exemption or extension shall only be valid for that calendar year.

Section 7. Reinstatement. Before a license is reinstated by the board under 201 KAR 18:115, a former professional land surveyor shall earn the continuing professional development hours required for each year the license was revoked, suspended, or expired, up to a maximum of thirty-two (32) professional development hours.

Section 8. Reporting. (1) A professional land surveyor shall certify whether or not he or she has complied with the requirements of this administrative regulation on the Electronic License Renewal Application, available at www.kyboels.ky.gov.

(2) Biennial renewal forms received after September 1 shall be subject to the audit process in Section 9 of this administrative regulation.

Section 9. Audits. (1) Compliance with the annual CPD requirements shall be determined through an audit process.

(2) Professional land surveyors shall be audited through a random selection process or as the result of information provided to the board.

(3) Individuals selected for audit shall within thirty (30) days of the board's request, provide the board with documentation of the CPD activities claimed for the renewal period. Appropriate documentation shall include:

(a) Verification records in the form of transcripts, completion certificates, or other documents supporting evidence of participation; or

(b) Information regarding seminar or course content, instructors, and sponsoring organizations.

(4) Individual licensees shall maintain verification records and documentation for audit purposes for the current reporting period and the two (2) previous reporting periods.

(5) If continuing professional development credit is disallowed, a professional land surveyor shall have 180 calendar days after notification to substantiate the original claim or earn other credit to meet the requirement.

(6) Failure to comply with the CPD requirements shall be considered a violation of KRS 322.180(3) subjecting the professional land surveyor to disciplinary action.

(7) An audit resulting in a determination of noncompliance shall subject the professional land surveyor to an automatic audit the next reporting period and each subsequent reporting period until an audit results in a determination of compliance.

(8) A professional land surveyor who is under investigation pursuant to KRS 322.190 may be subjected to the audit

requirements of this section.

Section 10. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Continuing Professional Development Course Approval Form", November 1999, State Board of Licensure for Professional Engineers and Land Surveyors; and

(b) "Electronic License Renewal Application", 2012.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at Kentucky State Board of Licensure for Professional Engineers and Land Surveyors, 160 Democrat Drive, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

B. DAVID COX, Executive Director

APPROVED BY AGENCY: April 10, 2014

FILED WITH LRC: April 11, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 21, 2014 at 1:30 p.m., local time, at 160 Democrat Drive, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing of their intent to attend no later than five workdays prior to the date of the hearing. If no written notification of an individual's intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. If the public hearing is held, any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made, in which case the person requesting the transcript shall have the responsibility of paying for same. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business, June 2, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

CONTACT PERSON: Jonathan Buckley, General Counsel, Kentucky State Board of Licensure for Professional Engineers and Land Surveyors, 160 Democrat Drive, Frankfort, Kentucky 40601, phone (502) 573-2680, fax (502) 573-6687.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Jonathan Buckley

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation implements the continuing professional development program mandated by KRS 322.290(14) for professional land surveyors.

(b) The necessity of this administrative regulation: KRS 322.290(14) mandates a professional development program for professional land surveyors.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation contains the details and requirements of the mandated professional development program.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation sets the requirements of the continuing professional development program for professional land surveyors so that the board can administer the program and inform licensees of the 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 contains two changes: First, it increases the membership of the Continuing Professional Development Committee from three members to five members, and increases from two to three, the number of those committee members that must be professional land surveyors; and second, it changes the required CPD course in standards of practice for professional land surveyors, professional ethics, and the code of professional practice and conduct from a board sponsored course, to one that the board has pre-approved.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary in order to provide a committee membership size that is sufficiently large enough to ensure having enough members in attendance to constitute a quorum at each meeting of the committee. Additionally, the board does not at this time, intend to sponsor any CPD courses, but will pre-approve those courses sponsored by others that meet the requirement of the four (4) hour course in standards of practice for professional land surveyors, professional ethics, and the code of professional practice and conduct; the regulation needs to be amended to reflect the position of the board with regard to those particular CPD courses.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to KRS 322.290(14) since that statute requires a professional development program for professional land surveyors.

(d) How the amendment will assist in the effective administration of the statutes: This amendment sets the requirements of the professional development program and provides the supporting regulatory language for the board to enforce the requirement of KRS 322.290(14).

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This regulation will affect the approximate 1,300 licensed professional land surveyors and the board itself.

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

(a) A detailed explanation of the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: No additional actions will be required of either the licensees or the board. The CPDC of the board will consider for pre-approval, any submissions by sponsors of courses meeting the provisions of Section 2(5) of this regulation, which is part of the normal activity of that committee.

(b) An estimate of the costs imposed on entities identified in question (3) in complying with this administrative regulation or amendment: There is no additional cost associated with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This amendment will result in clarity of application of the regulation and enable the board to avoid potential quorum difficulties in the meetings of the CPDC of the board.

(5) Provide an estimate of how much it will cost 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: Restricted Agency Funds. The board receives no general or federal funds.

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

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: No fees are established or increased as a result of this regulation.

(9) TIERING: Is tiering applied? Tiering was not used because this regulation should not disproportionately affect any particular group of people.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky State Board of Licensure for Professional Engineers and Land

Surveyors.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. 201 KAR 18:192; KRS 322.290(14)

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

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

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

(c) How much will it cost to administer this program for the first year? There will be no additional cost involved in administering this program for the first year.

(d) How much will it cost to administer this program for subsequent years? There will be no additional cost involved in administering this program for the subsequent years.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation: There is no additional cost or revenue generated by this amendment.

GENERAL GOVERNMENT CABINET
Board of Nursing
(Amendment)

201 KAR 20:056. Advanced practice registered nurse licensure and certification requirements[~~, program requirements, recognition of a national certifying organization~~].

RELATES TO: KRS 218A.205(3)(g), (7), 314.011, 314.042, 314.091, 314.103, 314.161, 314.470

STATUTORY AUTHORITY: KRS 218A.205(3)(g), (7), 314.042, 314.103, 314.131(1)

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 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)(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) 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.

(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, 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.

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 population focus as 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 board recognizes the Oncology Nursing Certification Corporation only for an individual who has received certification prior to December 15, 2010 and who has continually renewed his or her 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 Licensure Renewal Application: 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)1. 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.

2. The license shall not be issued until a report is received from the FBI and any conviction is addressed by the board;

(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)1. 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 prior to its expiration date after a request by the board shall have the APRN license voided. This action shall not be considered to be a disciplinary action.

2. 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, except as provided in subparagraph 3 of this paragraph.

3. If, after the APRN license has been voided, the APRN provides evidence that the certification had not lapsed, then the APRN shall meet the requirements of Section 6 of this administrative regulation except for Section 6(3)(a)2. A license may be issued prior to receipt of the FBI report.

(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 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.

Section 12. Dual designations. (1) An advanced practice registered nurse who wishes to practice in more than one (1) designation shall complete an approved organized postbasic program of study and clinical experience in the desired designation in compliance with the educational requirements set forth in KRS

Chapter 314 and 201 KAR 20:062 and meet all requirements for licensure in each additional designation.

(2) To apply for licensure for more than one (1) designation, the applicant shall submit a separate application and fee for each desired designation.

(3) To renew each designation, the APRN shall pay a separate licensure fee as set forth in 201 KAR 20:240, Section 1(2)(l).

(4) For the purposes of Section 7(2)(b) of this administrative regulation, if the APRN does not provide evidence of current recertification in one (1) of the designations, then that designation shall be voided. The license shall not be voided so long as the other designation is maintained. All other provisions of that section shall apply to the voided designation.

(5) Designations are Nurse Anesthetist, Nurse Midwife, Nurse Practitioner, and Clinical Nurse Specialist.

SALLY BAXTER, President

APPROVED BY AGENCY: April 10, 2014

FILED WITH LRC: April 11, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 27, 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 May 20, 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 close of business June 2, 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 licensure and certification requirements for Advanced Practice Registered Nurses (APRN).

(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 requirements.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By setting 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 allows for faster licensure by reinstatement after a license has been voided for lapsed certification. It also provides a process for dual designations.

(b) The necessity of the amendment to this administrative regulation: APRNs with dual designations requested clarification of the licensure process. The reinstatement process was shortened because of the delay in receiving a criminal background report from the FBI.

(c) How the amendment conforms to the content of the authorizing statutes: The Board is authorized to set requirements.

(d) How the amendment will assist in the effective administration of the statutes: By specifying the requirements.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: APRNs, approximately 5,300.

(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 follow the new process.

(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 new cost.

(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? Unknown.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Unknown.

(c) How much will it cost to administer this program for the first year? 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:

GENERAL GOVERNMENT CABINET
Board of Nursing
(Amendment)

201 KAR 20:057. Scope and standards of practice of advanced practice registered nurses.

RELATES TO: KRS 218A.205(3)(a), 314.011(7), 314.042, 314.193(2)

STATUTORY AUTHORITY: KRS 218A.205(3)(a), 314.131(1), 314.193(2)

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. KRS 314.193(2) authorizes the board to promulgate administrative regulations establishing standards for the performance of advanced practice registered nursing to safeguard the public health and welfare. This administrative regulation establishes the scope and standards of practice for an advanced practice registered nurse.

Section 1. Definitions. (1) "Collaboration" means the relationship between the advanced practice registered nurse and a physician in the provision of prescription medication, including both autonomous and cooperative decision-making, with the advanced practice registered nurse and the physician contributing their respective expertise.

(2) "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances" or "CAPA-CS" means the written document pursuant to KRS 314.042(9).

(3) "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs" or "CAPA-NS" means the written document pursuant to KRS 314.042(8).

Section 2. (1) The practice of the advanced practice registered nurse shall be in accordance with the standards and functions defined in[~~the following~~] scope and standards of practice statements adopted by the board in subsection (2) of this section.

(2) The following scope and standards of practice statements are adopted:

(a)[~~for each specialty area: (1)~~] Scope and Standards of Psychiatric-Mental Health Nursing Practice;

(b)[~~(2)~~] Nursing: Scope and Standards of Practice;

(c) Standards for Office Based Anesthesia Practice[~~(3) Scope and Standards for Nurse Anesthesia Practice~~];

(d)[~~(4)~~] Standards for Nurse Anesthesia Practice;

(e) Scope of Nurse Anesthesia Practice[~~Office-based Anesthesia Practice~~];

(f)[~~(5)~~] Standards for the Practice of Midwifery;

(g)[~~(6)~~] The Women's Health Nurse Practitioner: Guidelines for Practice and Education;

(h)[~~(7)~~] Pediatric Nursing: Scope and Standards of Practice;

(i)[~~(8)~~] Standards of Practice for Nurse Practitioners;

(j)[~~(9)~~] Scope of Practice for Nurse Practitioners;

(k) AACN[~~(10)~~] Scope and Standards[~~of Practice~~] for[~~the~~] Acute Care Nurse Practitioner Practice;

(l)[~~(11)~~] Neonatal Nursing: Scope and Standards of Practice;

(m) AACN[~~(12)~~] Scope and Standards for Acute and Critical Care Clinical Nurse Specialist Practice; and

(n)[~~(13)~~] Statement on the Scope and Standards of Oncology Nursing Practice: Generalist and Advanced Practice[~~Advanced Practice Nursing in Oncology~~].

Section 3. In the performance of advanced practice registered nursing, the advanced practice registered nurse shall seek consultation or referral in those situations outside the advanced practice registered nurse's scope of practice.

Section 4. Advanced practice registered nursing shall include prescribing medications and ordering treatments, devices, and diagnostic tests which are consistent with the scope and standard of practice of the advanced practice registered nurse.

Section 5. Advanced practice registered nursing shall not preclude the practice by the advanced practice registered nurse of registered nursing practice as defined in KRS 314.011(5).

Section 6. (1) A CAPA-NS and a CAPA-CS shall include the name, address, phone number, and license number of both the advanced practice registered nurse and each physician who is a party to the agreement. It shall also include the specialty area of practice of the advanced practice registered nurse.[~~An advanced practice registered nurse shall, upon request, furnish to the board or its staff, a copy of the CAPA-NS.~~]

(2)(a) To notify the board of the existence of a CAPA-NS pursuant to KRS 314.042(8)(b), the APRN shall file with the board the Notification of a Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs (CAPA-NS).

(b) To notify the board that the requirements of KRS 314.042(9) have been met and that the APRN will be prescribing nonscheduled legend drugs without a CAPA-NS, the APRN shall file the Notification to Discontinue the CAPA-NS After Four Years.

(c) To notify the board of the existence of a CAPA-CS pursuant to KRS 314.042(10)[~~(9)~~](a), the APRN shall file with the board the ["]Notification of a Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances (CAPA-CS)["].

(3) For purposes of the CAPA-NS and the CAPA-CS, in determining whether the APRN and the collaborating physician are qualified in the same or a similar specialty, the board shall be guided by the facts of each particular situation and the scope of the APRN's and the physician's actual practice.

(4)(a) An APRN with a CAPA-CS shall report all of his or her United States Drug Enforcement Agency (DEA) Controlled Substance Registration Certificate numbers to the board when issued to the APRN by mailing a copy of each[~~the~~] registration certificate to the board within thirty (30) days of issuance.

(b) Any change in the status of a[~~the~~] DEA Controlled Substance Registration Certificate number shall be reported in writing to the board within thirty (30) days.

Section 7. Prescribing medications without a CAPA-NS or a CAPA-CS shall constitute a violation of KRS 314.091(1), except when a CAPA-NS has been discontinued pursuant to KRS 314.042(9).

Section 8. The board may make an unannounced monitoring visit to an advanced practice registered nurse to determine if the advanced practice registered nurse's practice is consistent with the requirements established by 201 KAR Chapter 20, and patient and prescribing records shall be made available for immediate inspection.

Section 9. Prescribing Standards for Controlled Substances. (1)(a) This section shall apply to an APRN with a CAPA-CS if prescribing a controlled substance other than a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(b) The APRN shall practice according to the applicable scope and standards of practice for the APRN's role and population focus.

(2) This section shall not apply to:

(a) An APRN prescribing or administering a controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or the delivery and the medication usage does not extend beyond the fourteen (14) days;

(b) An APRN prescribing or administering a controlled substance necessary to treat a patient in an emergency situation; or

(c) An APRN prescribing a controlled substance:

1. For administration in a hospital or long-term-care facility with

an institutional account, or an APRN in a hospital or facility without an institutional account, if the hospital, long-term-care facility, or licensee queries KASPER for all available data on the patient or resident for the twelve (12) month period immediately preceding the query within twelve (12) hours of the patient's or resident's admission and places a copy of the query in the patient's or resident's medical records during the duration of the patient's stay at the facility;

2. As part of the patient's hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing pursuant to subsection (1) of this section if the prescribing:

a. Is done as a substitute for the initial prescribing;

b. Cancels any refills for the initial prescription; and

c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescribing pursuant to subsection (1) of this section if the prescribing is done by another licensee in the same practice or in an existing coverage arrangement, if done for the same patient for the same medical condition;

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federal-wide assurance number from the United States Department of Health and Human Services, Office for Human Research Protections if the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health;

8. During the effective period of any disaster or situation with mass casualties that have a direct impact on the APRN's practice;

9. Administering or prescribing controlled substances to prisoners in a state, county, or municipal correctional facility;

10. Prescribing a Schedule IV controlled substance for no longer than three (3) days for an established patient to assist the patient in responding to the anxiety of a nonrecurring event; or

11. That has been classified as a Schedule V controlled substance.

(3) The APRN shall, prior to initially prescribing a controlled substance for a medical complaint for a patient:

(a) Obtain the patient's medical history and conduct an examination of the patient and document the information in the patient's medical record. An APRN certified in psychiatric/mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient's medical record;

(b) Query KASPER for all available data on the patient;

(c) Make a written treatment plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate:

1. The risks and benefits of the use of controlled substances, including the risk of tolerance and drug dependence;

2. That the controlled substance should be discontinued when the condition requiring its use has resolved; and

3. Document that the discussion occurred and that the patient consented to the treatment.

(4) The treatment plan shall include an exit strategy, if appropriate, including potential discontinuation of the use of controlled substances.

(5) For subsequent or continuing long-term prescriptions of a controlled substance for the same medical complaint, the APRN shall:

(a) Update the patient's medical history and document the information in the patient's medical record;

(b) Modify the treatment plan as clinically appropriate; and

(c) Discuss the risks and benefits of any new controlled substances prescribed with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence.

(6) During the course of treatment, the APRN shall query KASPER no less than once every three (3) months for all available data on the patient before issuing a new prescription or a refill for a controlled substance.

(7) These requirements may be satisfied by other licensed practitioners in a single group practice if:

(a) Each licensed practitioner involved has lawful access to the patient's medical record;

(b) Each licensed practitioner performing an action to meet these requirements is acting within the scope of practice of his or her profession; and

(c) There is adequate documentation in the patient's medical record reflecting the actions of each practitioner.

(8) If prescribing a controlled substance for the treatment of chronic, noncancer pain, the APRN, in addition to the requirements of this section, shall obtain a baseline drug screen or further random drug screens if the APRN:

(a) Deems a drug screen to be clinically appropriate; or

(b) Believes that it is appropriate to determine whether or not the controlled substance is being taken by the patient.

(9) If prescribing a controlled substance for the treatment of a mental health condition, the APRN shall meet the requirements of this section.

(10) If prescribing a controlled substance for a patient younger than sixteen (16) years of age, the APRN shall obtain and review an initial KASPER report. If prescribing a controlled substance for an individual sixteen (16) years of age or older, the requirements of this section shall apply.

(11) Prior to prescribing a controlled substance for a patient in the emergency department of a hospital that is not an emergency situation as specified in subsection (2) of this section, the APRN shall:

(a) Obtain the patient's medical history, conduct an examination of the patient and document the information in the patient's medical record. An APRN certified in psychiatric/mental health shall obtain a medical and psychiatric history, perform a mental health assessment, and document the information in the patient's medical record;

(b) Query KASPER for all available data on the patient;

(c) Make a written treatment plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence and document that the discussion occurred and that the patient consented to the treatment.

Section 10. Prescribing Standards for Controlled Substances from Schedule II and Schedule III Containing Hydrocodone. (1)(a) This section shall apply to an APRN with a CAPA-CS if prescribing a controlled substance from Schedule II or Schedule III controlled substance containing hydrocodone.

(b) The APRN shall practice according to the applicable scope and standards of practice for the APRN's role and population focus.

(2) This section shall not apply to:

(a) An APRN prescribing or administering a controlled substance immediately prior to, during, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or the delivery and the medication usage does not extend beyond the fourteen (14) days;

(b) An APRN prescribing or administering a controlled substance necessary to treat a patient in an emergency situation; or

(c) An APRN prescribing a controlled substance:

1. For administration in a hospital or long-term-care facility with an institutional account, or an APRN in a hospital or facility without an institutional account, if the hospital, long-term-care facility, or licensee queries KASPER for all available data on the patient or

resident for the twelve (12) month period immediately preceding the query within twelve (12) hours of the patient's or resident's admission and places a copy of the query in the patient's or resident's medical records during the duration of the patient's stay at the facility;

2. As part of the patient's hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing pursuant to subsection (1) of this section if the prescribing or dispensing:

a. Is done as a substitute for the initial prescribing;

b. Cancels any refills for the initial prescription; and

c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescribing pursuant to subsection (1) of this section if the prescribing is done by another licensee in the same practice or in an existing coverage arrangement, if done for the same patient for the same medical condition; or

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federal-wide assurance number from the United States Department of Health and Human Services, Office for Human Research Protections if the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health.

(3) Prior to the initial prescribing of a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, an APRN shall:

(a) Obtain a medical history and conduct a physical or mental health examination of the patient, as appropriate to the patient's medical complaint, and document the information in the patient's medical record;

(b) Query the electronic monitoring system established in KRS 218A.202 for all available data on the patient for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient;

(c) Make a written plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(e) Obtain written consent for the treatment.

(4)(a) An APRN prescribing an additional amount of a Schedule II controlled substance or Schedule III controlled substance containing hydrocodone for the same medical complaint and related symptoms shall:

1. Review the plan of care at reasonable intervals based on the patient's individual circumstances and course of treatment;

2. Provide to the patient any new information about the treatment; and

3. Modify or terminate the treatment as appropriate.

(b) If the course of treatment extends beyond three (3) months, the licensee shall:

1. Query KASPER no less than once every three (3) months for all available data on the patient for the twelve (12) month period immediately preceding the query; and

2. Review that data before issuing any new prescription or refills for the patient for any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(5) For each patient for whom an APRN prescribes a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone, the licensee shall keep accurate, readily accessible, and complete medical records, which include, as appropriate:

(a) Medical history and physical or mental health examination;

(b) Diagnostic, therapeutic, and laboratory results;

(c) Evaluations and consultations;

(d) Treatment objectives;

(e) Discussion of risk, benefits, and limitations of treatments;

(f) Treatments;

(g) Medications, including date, type, dosage, and quantity prescribed;

(h) Instructions and agreements; and

(i) Periodic reviews of the patient's file.

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

(a) "Scope and Standards of Psychiatric-Mental Health Nursing Practice", 2007 Edition, American Nurses' Association;

(b) "Nursing: Scope and Standards of Practice", 2010 Edition, American Nurses' Association;

(c) "Standards for Office-based Anesthesia Practice", 2013[~~2010~~] Edition, American Association of Nurse Anesthetists;

(d) "[~~Scope and~~]Standards for Nurse Anesthesia Practice", 2013[~~2010~~] Edition, American Association of Nurse Anesthetists;

(e) "Scope of Nurse Anesthesia Practice", 2013 Edition, American Association of Nurse Anesthetists;

(f) "Standards for the Practice of Midwifery", 2011 Edition, American College of Nurse-midwives;

(g)[~~(f)~~] "The Women's Health Nurse Practitioner: Guidelines for Practice and Education", 2008 Edition, Association of Women's Health, Obstetric and Neonatal Nurses and National Association of Nurse Practitioners in Women's Health;

(h)[~~(g)~~] "Pediatric Nursing: Scope and Standards of Practice", 2008 Edition,
National Association of Pediatric Nurse Practitioners;

(i)[~~(h)~~] "Standards of Practice for Nurse Practitioners", 2013[~~2010~~] Edition, American Academy of Nurse Practitioners;

(j)[~~(i)~~] "Scope of Practice for Nurse Practitioners", 2013[~~2010~~] Edition, American Academy of Nurse Practitioners;

(k)[~~(j)~~] "AACN Scope and Standards[~~of Practice~~] for[~~the~~] Acute Care Nurse Practitioner Practice", 2012[~~2006~~] Edition. American Association of Critical Care Nurses;

(l)[~~(k)~~] "Neonatal Nursing: Scope and Standards of Practice", 2013[~~2004~~] Edition, American Nurses Association/National Association of Neonatal Nurses;

(m)[~~(l)~~] "Scope and Standards for Acute and Critical Care Clinical Nurse Specialist Practice", 2010 Edition, American Association of Critical-Care Nurses;

(n)[~~(m)~~] "Statement on the Scope and Standards of Oncology Nursing Practice: Generalist and Advanced Practice[~~Advanced Practice Nursing in Oncology~~]", 2013[~~2003~~] Edition, Oncology Nursing Society;[~~and~~]

(o)[~~(n)~~] "Notification of a Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances (CAPA-CS)", 6/2010, Kentucky Board of Nursing;

(p) "Notification of a Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs (CAPA-NS)", 4/2014, Kentucky Board of Nursing; and

(q) "Notification to Discontinue the CAPA-NS After Four Years", 4/2014, Kentucky Board of Nursing.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, Monday through Friday, 8 a.m. to 4:30 p.m.

SALLY BAXTER, President

APPROVED BY AGENCY: April 10, 2014

FILED WITH LRC: April 11, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 27, 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 May 20, 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 close of business June 2, 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 the scope and standards of practice for Advanced Practice Registered Nurses (APRN).

(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.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By setting 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 updates several Scope and Standards statements. It also implements Senate Bill 7 (2014 Regular Session).

(b) The necessity of the amendment to this administrative regulation: Periodic updates of the national organizations' scope and standards publications is necessary. Also, Senate Bill 7 requires some implementation by regulation.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to set standards.

(d) How the amendment will assist in the effective administration of the statutes: By setting the standards.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: APRNs, approximately 5,300.

(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 follow the new procedures.

(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 new cost.

(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:

GENERAL GOVERNMENT CABINET
Board of Nursing
(Amendment)

201 KAR 20:161. Investigation and disposition of complaints.

RELATES TO: KRS Chapter 13B, 218A.205, 314.011(13), 314.031, 314.071(4), 314.091, 314.107, 314.470, 314.991(3)

STATUTORY AUTHORITY: KRS 218A.205, 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.131(1) authorizes the Board of Nursing to promulgate administrative regulations to effect the provisions of KRS Chapter 314. This administrative regulation establishes the procedures for the investigation and disposition of complaints received by the board.

Section 1. Receipt of Complaints. (1) The board shall receive and process each complaint made against a licensee, holder of a multistate licensure privilege pursuant to KRS 314.470, or applicant or unlicensed individual if the complaint alleges acts that may be in violation of the provisions of KRS Chapter 314.

(2)(a) A complaint shall be in writing and shall be dated and fully identify the individual by name.

(b) The president of the board or the executive director or designee shall file a complaint based upon information received by oral, telephone, or written communications if the facts of the complaint are determined to be accurate and indicate acts that may be in violation of the provisions of KRS Chapter 314.

(3) A certified copy of a court record for a misdemeanor or felony conviction or a certified copy of disciplinary action in another jurisdiction shall be considered a valid complaint.

(4) A complaint shall be investigated.

(a) If the complaint sets forth a potential violation or the conduct falls within the statutory instances which must be investigated, the board shall send a copy of the complaint to the

licensee, holder of a multistate privilege, or applicant to the address of record.

(b) A written, legible, verified response shall be filed with the board within thirty (30) days of receipt by the individual against whom the complaint has been made.

(c) The staff may request an informal conference with the individual against whom the complaint has been made.

(5)(a) A complaint shall be evaluated to determine if a violation of the provisions of KRS Chapter 314 has been alleged.

(b) The credentials review panel or the executive director or designee shall make the determination as to the disposition of the complaint pursuant to Section 2 of this administrative regulation.

(6)(a) All preliminary information shall be treated as confidential during the investigation and shall not be disclosed to board members or to the public, except as provided by KRS 314.470. The board shall make available to the public the fact that an investigation is pending.

(b) If a board member has participated in the investigation or has substantial knowledge of facts prior to a hearing on the complaint that may influence an impartial decision by the member, that member shall not participate in the adjudication of the complaint.

(7)(a) When the board receives a report of improper, inappropriate, or illegal prescribing or dispensing of a controlled substance by an advanced practice registered nurse (APRN), it shall notify, within three (3) business days:

1. The Department of Kentucky State Police;

2. The Office of the Attorney General; and

3. The Cabinet for Health and Family Services, Office of the Inspector General.

(b) An investigation concerning a complaint filed against an APRN pertaining to the improper, inappropriate, or illegal prescribing or dispensing of controlled substances shall be commenced within seven (7) days of the filing of the complaint.

(c) The investigation shall be completed and a determination as to the disposition of the complaint shall be made within 120 days of the receipt of the complaint, unless an extension of time is requested by a law enforcement agency due to an ongoing criminal investigation.

Section 2. Disposition of Complaints. (1) Disposition of complaints shall be as follows:

(a) If there is a determination by the executive director or designee that there is insufficient evidence of a violation or that a violation has not occurred, there shall not be further action unless warranted by future evidence;

(b)1. The complaint may be referred to the credentials review panel of the board by the executive director or designee for disposition pursuant to this section or for issuance of a letter of concern; or

2. It may be determined that there is probable cause that a violation of KRS 314.091 has occurred.

(c) In cases involving practice as a nurse on the privilege pursuant to KRS 314.470, the case may be referred to the home state.

(2) Upon determination that there is probable cause that a violation of KRS 314.091 has occurred, the complaint shall be handled as follows:

(a) An administrative hearing may be scheduled pursuant to subsection (3) of this section;

(b) An agreed order may be offered pursuant to subsection (4) of this section; or

(c) A consent decree may be offered, pursuant to subsection (5) of this section.

(3) Administrative hearings.

(a) Hearings shall be held pursuant to KRS 314.091, Chapter 13B, and 201 KAR 20:162.

(b) Notice of the hearing and charges shall be mailed by certified mail to the address of the licensee or applicant on file with the board pursuant to KRS 314.107.

(c) Notice of the hearing and charges shall be signed by the executive director or designee.

(4) Agreed order.

(a) The board may enter into an agreement with an individual for denial, revocation, voluntary surrender, suspension, probation, reinstatement, limitation of license or reprimand, and to impose a civil penalty, if the individual agrees to waive the right to a hearing. The terms of the agreement may include other conditions or requirements to be met by the individual, including those listed in Section 4 of this administrative regulation.

(b) The agreed order may contain terms that insure protection of public health and safety or that serve to educate or rehabilitate the individual.

(c) The agreed order, if approved by the board, shall terminate the investigation of a specific complaint.

(d) If the agreed order is not approved by the board, charges may be brought pursuant to KRS 314.091, and the matter shall be resolved as directed therein.

(5) Consent decree.

(a) If an individual agrees to waive the right to a hearing, the board may issue a consent decree in accordance with the provisions of KRS 314.991 to impose a civil penalty and other terms and conditions as listed in Section 4 of this administrative regulation against an individual who has:

1. Practiced as a nurse in the Commonwealth of Kentucky without a temporary work permit, multistate licensure privilege pursuant to KRS 314.470, or a current license or provisional license issued by the board;

2. Practiced as an advanced practice registered nurse in the Commonwealth of Kentucky without current licensure issued by the board prior to filing an application for licensure;

3. Practiced as an advanced practice registered nurse after expiration of the current certification granted by the appropriate national organization or agency;

4. Cured noncompliance with continuing education requirements, as set forth in 201 KAR 20:215, Section 3;

5. Executed an affidavit of reasonable cause concerning the AIDS education requirement and obtained the required education after the expiration of the six (6) months;

6. Tested positive on a drug screen for a nonprescribed drug or illicit substance and obtained a chemical dependency evaluation that does not indicate a diagnosis of chemical dependency;

7. Failed to report a criminal conviction or disciplinary action against any professional license or credential in Kentucky or in another jurisdiction on an application;[~~or~~]

8. Committed a substandard nursing act where:

a. The continuing practice by the nurse does not pose a risk of harm to the client or another;

b. The potential risk of physical, emotional, or financial harm to the client due to the incident is minimal;

c. The nurse subsequently exhibits a conscientious approach to and accountability for his or her practice; and

d. The nurse subsequently has demonstrated the knowledge and skill to practice safely; or

9. As an advanced practice registered nurse with a Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS):

a. Failed to register with KASPER;

b. Failed to report a DEA registration number to the board; or

c. Failed to notify the board of the CAPA-CS.

(b) The issuance of a consent decree shall be restricted to only those individuals described in paragraph (a) of this subsection who have not previously been issued a consent decree for the same or substantially similar violation and who have not violated any other provision of KRS Chapter 314 or any other laws of the Commonwealth of Kentucky or of the United States.

(c) The license may be issued by board staff after the individual meets all requirements for licensure upon ratification of the consent decree by the board.

(d) Upon ratification by the board of the consent decree, the investigation of the specific complaint shall be terminated.

(e) If the consent decree is not ratified by the board, charges may be brought pursuant to KRS 314.091, and the matter shall be resolved as directed therein.

(f) Consent decrees that have been ratified by the board shall not be reported to other state boards of nursing, the national

council of state boards of nursing, or other organizations, unless required by law.

(6) Special standards for an Advanced Practice Registered Nurse (APRN) with a Collaborative Agreement for Prescriptive Authority for Controlled Substances (CAPA-CS).

(a) An APRN licensed in Kentucky or an applicant for licensure in Kentucky who has been convicted of any felony offense after July 20, 2012 relating to controlled substances in any state shall be permanently banned from prescribing controlled substances.

(b) An APRN licensed in Kentucky or an applicant for licensure in Kentucky who has been convicted of any misdemeanor offense after July 20, 2012 relating to prescribing or dispensing controlled substances in any state shall have their authority to prescribe controlled substances suspended for at least three (3) months and as further restricted as determined by the board.

(c) The board shall mirror in time and scope any disciplinary limitation placed on an APRN licensed in Kentucky by a licensing board of another state if the disciplinary action resulted from improper, inappropriate, or illegal prescribing or dispensing of controlled substances.

(d) An applicant for licensure in Kentucky as an APRN who has disciplinary action by a licensing board of another state which resulted from improper, inappropriate, or illegal prescribing or dispensing of controlled substances shall have his or her application denied.

(e) Cases that come under KRS 314.011(21)(c) shall not be considered convictions for the purpose of this subsection.

Section 3. The executive director or designee shall notify the complainant and the person against whom the complaint was made of the final disposition of the case.

Section 4. The restrictions or conditions imposed by the board on a temporary work permit, holder of a multistate licensure privilege, or license or provisional license may include the following:

(1) Prohibiting the performance of specific nursing acts including access to, responsibility for, or the administration of controlled substances; administration of medication; supervisory functions; or any act that the individual is unable to safely perform;[.]

(2) Requiring the individual have continuous, direct, on-site supervision by a licensed nurse, physician, or dentist;[.]

(3) Specifying the individual's practice setting;[.]

(4) Specifying the types of patients to whom the individual may give nursing care;[.]

(5) Requiring the individual to notify the board in writing of a change in name, address, or employment;[.]

(6) Requiring the individual to have his or her employer submit to the board written reports of performance or compliance with the requirements set by the board;[.]

(7) Requiring the individual to submit to the board evidence of physical or chemical dependency, mental health evaluations, counseling, therapy, or drug screens;[.]

(8) Meeting with representatives of the board;[.]

(9) Issuing the license or temporary work permit for a specified period of time;[.]

(10) Requiring the individual to notify the board in writing of criminal arrests, charges, or convictions;[.]

(11) Requiring the individual to be employed as a nurse for a specified period of time; or[.]

(12) Requiring the individual to complete continuing education in a specific subject.

Section 5. Anonymous complaints. Section 1(2)(a) of this administrative regulation notwithstanding, the board shall accept an anonymous complaint so long as the complaint is accompanied by sufficient corroborating evidence as would allow the board to believe, based upon a totality of the circumstances, that a reasonable probability exists that the complaint is meritorious.

Section 6. In accordance with federal law, the board shall submit all disciplinary actions to the National Practitioner Data Bank of the United States Department of Health and Human Services either directly or through a reporting agent.

SALLY BAXTER, President

APPROVED BY AGENCY: April 10, 2014

FILED WITH LRC: April 11, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 27, 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 May 20, 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 close of business June 2, 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 the procedures for investigation and disposition of disciplinary complaints.

(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 procedures.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By setting procedures.

(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 adds several situations to the consent decree procedures: (1) action on another professional license and (2) certain APRN prescriber-related functions.

(b) The necessity of the amendment to this administrative regulation: It is necessary to update the procedures to reflect changes in the law.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to set these matters.

(d) How the amendment will assist in the effective administration of the statutes: By updating the procedures.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Affected nurses (those with specific kinds of complaints), 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:

They will have to follow the new procedures.

(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 new cost.

(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? Unknown.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Unknown.

(c) How much will it cost to administer this program for the first year? 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:

GENERAL GOVERNMENT CABINET
Board of Nursing
(Amendment)

201 KAR 20:370. Applications for licensure.

RELATES TO: KRS 314.041, 314.042, 314.051, 314.071, 314.091

STATUTORY AUTHORITY: KRS 314.041, 314.051, 314.071, 314.131(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.131(1) authorizes the Board of Nursing to promulgate administrative regulations as may be necessary to enable it to carry into effect the provisions of KRS Chapter 314. 314.041, 314.051, and 314.071 require the board to review an application for licensure and a licensee for conformity with KRS Chapter 314. This administrative regulation establishes requirements and procedures for licensure.

Section 1. To be eligible for licensure by examination, endorsement, renewal, reinstatement, retired licensure status, or for advanced practice registered nurse licensure, renewal, or reinstatement, an applicant shall:

(1) Submit the appropriate completed application form to the board office, as follows:

(a) For RN or LPN licensure by examination, endorsement, or reinstatement, ["]Application for Licensure["];

(b) For RN or LPN Renewal, ["]Annual Licensure Renewal Application: RN or LPN["];

(c) For licensure or reinstatement as an advanced practice registered nurse, ["]Application for Licensure as an Advanced Practice Registered Nurse["];

(d) For renewal as an RN and an APRN, ["]Annual Licensure Renewal Application: RN and APRN["];

(e) For licensure as an RN and as an APRN, ["]Application for RN and APRN Licensure["];

(f) For retired licensure status, ["]Application for Retired Status["];

(g) For APRN renewal with an RN Compact license, ["]Annual Licensure Renewal Application: APRN with RN Compact License (not Kentucky) ["]; or

(h) In addition to any other renewal form, for APRN renewal, ["]APRN Practice Data["];

(2) Submit the current application fee, as required by 201 KAR 20:240;

(3) Submit a certified copy of the court record of each misdemeanor or felony conviction in this or any other jurisdiction and a letter of explanation that addresses each conviction, except for traffic-related misdemeanors (other than DUI) or misdemeanors older than five (5) years;

(4) Submit a certified copy of a disciplinary action taken in another jurisdiction with a letter of explanation or report a disciplinary action pending on a nurse licensure application or license in another jurisdiction;

(5) Have paid all monies due to the board;

(6) Submit a copy of an official name change document (court order, marriage certificate, divorce decree, Social Security card), if applicable;

(7) Submit additional information as required by the board in 201 KAR Chapter 20;

(8) Meet the additional requirements for:

(a) Licensure by examination established by 201 KAR 20:070;

(b) Licensure by endorsement established by 201 KAR 20:110;

(c) Licensure by reinstatement established by 201 KAR 20:225;

(d) Licensure by renewal established by 201 KAR 20:230;

(e) Retired nurse or inactive licensure status established by 201 KAR 20:095; or

(f) Advanced practice registered nurse licensure, renewal, or reinstatement established by 201 KAR 20:056;

(9) If not a citizen of the United States, maintain proof of legal permanent or temporary residency under the laws and regulations of the United States; and

(10) Notify the board upon establishment of a new mailing address.

Section 2. A completed renewal application form and all information needed to determine that an applicant meets the requirements for renewal of licensure shall be postmarked or received by the board no later than the last day for renewal of license.

Section 3. 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 the date the applicant fails the examination, whichever comes first; or

(3) For all other applications except renewal of license applications, within one (1) year from the date the application form is filed with the board office.

Section 4. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Application for Licensure", 2/2014[~~6/2011~~], Kentucky Board of Nursing;

(b) "Annual Licensure Renewal Application: RN or LPN", 2/2014[~~6/2012~~], Kentucky Board of Nursing;

(c) "Application for Licensure as an Advanced Practice Registered Nurse", 2/2014[~~6/2011~~], Kentucky Board of Nursing;

(d) "Annual Licensure Renewal Application: RN and APRN", 2/2014[~~6/2012~~], Kentucky Board of Nursing;

(e) "Application for RN and APRN Licensure", 2/2014[~~6/2011~~], Kentucky Board of Nursing;

(f) "Application for Retired Status", 8/2004, Kentucky Board of Nursing;

(g) "Annual Licensure Renewal Application: APRN with RN Compact License (not Kentucky)", 2/2014[~~6/2012~~], Kentucky Board of Nursing; and

(h) "APRN Practice Data", 6/2012, Kentucky Board of Nursing.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222, Monday through Friday, 8 a.m. to 4:30 p.m.

SALLY BAXTER, President

APPROVED BY AGENCY: February 21, 2014

FILED WITH LRC: April 11, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 27, 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 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 close of business, June 2, 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 incorporates applications for licensure.

(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 incorporating application forms.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By incorporating application forms.

(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: Several application forms are being updated.

(b) The necessity of the amendment to this administrative regulation: Questions concerning criminal and disciplinary history were confusing to applicants. Language was rewritten to be clearer.

(c) How the amendment conforms to the content of the authorizing statutes: The Board is authorized to create application forms.

(d) How the amendment will assist in the effective administration of the statutes: By updating the application forms.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Applicants for licensure, 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: Applicants will use the new forms.

(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.

(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:

GENERAL GOVERNMENT CABINET
Board of Nursing
(Amendment)

201 KAR 20:411. Sexual Assault Nurse Examiner Program standards and credential requirements.

RELATES TO: KRS 216B.400(2), (4), 314.011(14), 314.103, 314.142, 314.470, 403.707, 421.500-421.575[421.550]

STATUTORY AUTHORITY: KRS 314.131(1), 314.142(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 314.131(1) authorizes the Board of Nursing to promulgate administrative regulations as may be necessary to enable it to carry into effect the provisions of KRS Chapter 314. KRS 314.142(1) requires the board to promulgate administrative regulations to create a Sexual Assault Nurse Examiner Program. This administrative regulation establishes the requirements relating to a sexual assault nurse examiner course and the credentials of a sexual assault nurse examiner.

Section 1. Definition. "SANE course" means a formal, organized course of instruction that is designed to prepare a registered nurse to perform forensic evaluation of a sexual assault victim fourteen (14) years of age or older and to promote and preserve the victim's biological, psychological, and social health.

Section 2. SANE Course Approval Application. (1) On the form ["]Application for Initial or Continued SANE Course Approval["], the applicant for approval of a SANE course shall submit evidence to the board of completion of the requirements for course approval that consists of the following documentation:

(a) Position description and qualifications of the nurse administrator of the SANE course;

(b) Qualifications and description of the faculty;

(c) Course syllabus;

(d) Course completion requirements;

(e) Tentative course presentation dates;

(f) Records maintenance policy; and

(g) Copy of certificate of course completion form.

(2)[(1)] Nurse administrator of SANE course. A registered nurse, with current, active Kentucky licensure or a multistate licensure privilege pursuant to KRS 314.470, a baccalaureate or higher degree in nursing, and experience in adult and nursing education shall be administratively responsible for assessment, planning, development, implementation, and evaluation of the SANE course.

(3)[(2)] Faculty qualifications. The course shall be taught by multidisciplinary faculty with documented expertise in the subject matter. The name, title, and credentials identifying the educational and professional qualifications for each instructor shall be provided as part of the application.

(4)[(3)] Course syllabus. The syllabus shall include:

(a) Course prerequisites, requirements, and fees.

(b) Course outcomes, which[. The outcomes] shall provide statements of observable competencies, which if taken as a whole, present a clear description of the entry level behaviors to be achieved by the learner.

(c) Unit objectives for an individual, which[. Individual unit objectives] shall be stated in operational or behavioral terms with supportive content identified.

(d) Content, which[. The content] shall be described in detailed outline format with corresponding lesson plans and time frame, and which[. The content] shall be related to, and consistent with, the unit objectives, and support achievement of expected course outcomes.

1. The SANE course shall include:

a. A minimum of forty (40) hours of didactic instruction pursuant to subparagraph 3 of this paragraph; and

b. The clinical practice experience required by subparagraph 2 of this paragraph.

2. Clinical practice. The clinical portion of the course shall be a minimum of sixty (60) hours and shall include:

a.[Supervised] Detailed genital and anal inspection, a minimum of sixteen (16) speculum examination, visualization techniques, and use of equipment supervised by a physician, a physician's assistant, an advanced practice registered nurse, or a SANE – twenty-six (26) hours;[.]

b.[Supervised] Mock sexual assault history taking and examination techniques with evaluation supervised by a physician, a physician's assistant, an advanced practice registered nurse, or a SANE - ten (10) hours;[.]

c. Observing relevant civil or criminal trials, meeting with the Commonwealth Attorney, or similar legal experience - sixteen (16) hours;[.]

d. Meeting with a rape crisis victim advocate or mental health professional with expertise in the treatment of a sexually assaulted individual[sexual assault individuals] – four (4) hours; and[.]

e. Meeting with members of law enforcement - four (4) hours.

3. The didactic portion of the course shall include instruction in the following topics related to forensic evaluation of an individual[individuals] reporting sexual assault:

a. The role and responsibilities of a sexual assault nurse examiner, health care professional, rape crisis, law enforcement, and judicial system personnel;

b. Application of the statewide medical protocol relating to the forensic and medical examination of an individual[individuals] reporting sexual assault pursuant to KRS 216B.400(2);

c. Principles and techniques of evidence identification, collection, evaluation, preservation, and chain of custody;

d. Assessment of injuries, including injuries of forensic significance;

e. Physician consultation and referral;

f. Medicolegal documentation;

g. Victim's bill of rights, KRS 421.500 through 421.575[421.550];

h. Crisis intervention;

i. Dynamics of sexual assault;

j. Testifying in court;

k. Overview of the criminal justice system and related legal issues;

l. Available community resources including rape crisis centers;

m. Historical development of the forensic nursing conceptual model;

n. Cultural diversity and special populations;

o. Ethics;

p. Genital anatomy, normal variances, and development stages;

q. Health care implications and interventions; and

r. Developing policies and procedures.

(e) Teaching methods. The activities of both instructor and learner shall be specified in relation to the content outline. These activities shall be congruent with stated course objectives and content, and reflect the application of adult learning principles.

(f) Evaluation. There shall be clearly defined methods for evaluating the learner's achievement of course outcomes. There shall[also] be a process for annual course evaluation by students, providers, faculty, and administration.

(g) Instructional or reference materials. All required instructional materials and reference materials shall be identified.

(5)[(4)] Completion requirements. Requirements for successful completion of the SANE course shall be clearly specified and shall include demonstration of clinical competency. A statement of policy regarding a candidate who fails to successfully complete the course shall be included.

Section 3. (1) Contact hour credit for continuing education. The SANE course shall be approved for contact hour credit which may be applied to licensure requirements.

(2) Approval period. Board approval for a SANE course shall be granted for a four (4) year period.

(3) Records shall be maintained for a period of five (5) years, including the following:

(a) Provider name, date, and site of the course; and

(b) Participant roster, containing at[with] a minimum the name, Social Security number, and license number for each participant[of names, Social Security numbers, and license numbers].

(4) A participant shall receive a certificate of completion that documents the following:

(a) Name of participant;

(b) Title of course, date, and location;

(c) Provider's name; and

(d) Name and signature of authorized provider representative.

Section 4. Continued Board Approval of a SANE Course. (1) An application for continued approval of a SANE course shall be submitted on the Application for Initial or Continued SANE Course Approval at least three (3) months prior to the end of the current approval period.

(2) A SANE course syllabus shall be submitted with the ["]Application for Initial or Continued SANE Course Approval["].

(3) Continued approval shall be based on the past approval period performance and compliance with the board standards described in this administrative regulation.

Section 5. The board may deny, revoke, or suspend the approval status of a SANE course for violation of this administrative regulation.

Section 6. Appeal. If a SANE course administrator is dissatisfied with a board decision concerning approval and wishes a review of the decision, the procedure established in this section shall be followed.[following procedure shall be followed:] (1) 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 SANE course administrator contests.

(2) The board, or its designee, shall conduct a review in which the SANE course administrator may appear in person and with counsel to present reasons why the board's decision should be set aside or modified.

Section 7. Requirements for Sexual Assault Nurse Examiner (SANE) Credential. (1) The applicant for the SANE credential shall:

(a) Hold a current, active registered nurse license in Kentucky or a multistate licensure privilege pursuant to KRS 314.470;

(b) Have completed a board approved SANE educational course or a comparable course;

1. The board or its designee shall evaluate the applicant's course to determine its course comparability; and

2. The board or its designee shall advise an applicant if the course is not comparable and specify what additional components shall be completed to allow the applicant to be credentialed;

(c) If the applicant has completed a comparable course, complete that portion of a SANE course of at least five (5) hours which shall include those topics specified in Section 2(4)[(3)](d)3a, b, c, g, k, and l of this administrative regulation if not included in the comparable course completed by the applicant.

1. The Office of the Attorney General may offer in cooperation with a board approved continuing education provider a course of at least five (5) hours.

2. The course shall[to] include those topics specified in this paragraph;

(d) Complete the ["]Sexual Assault Nurse Examiner Application for Credential["];

(e) Pay the fee established in 201 KAR 20:240;

(f) Provide a completed Federal Bureau of Investigation (FBI) Applicant Fingerprint Card and pay the fee required by the FBI that is within six (6) months of the date of the application;

(g) Provide 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;

(h) Provide a certified copy of the court record of any misdemeanor or felony conviction as required by 201 KAR 20:370, Section 1(3); and

(i) Provide a letter of explanation that addresses each conviction, if applicable.

(2) Upon completion of the application process, the board shall issue the SANE credential for a period ending October 31.

(3) An applicant shall not be credentialed until a report is received from the FBI pursuant to the request submitted under subsection (1)(f) of this section and any conviction is addressed by the board.

Section 8. Renewal. (1) To renew the SANE credential for the next period, each sexual assault nurse examiner shall complete at least five (5) contact hours of continuing education related to the role of the sexual assault nurse examiner within each continuing education earning period. A provider of a board approved SANE course may offer continuing education related to the role of the sexual assault nurse examiner.

(2) Upon completion of the required continuing education, completion of the ["]SANE Renewal Application["] or ["]Annual Credential Renewal Application: SANE with RN Compact License (Not Kentucky)["], as applicable, and payment of the fee established in 201 KAR 20:240, the SANE credential shall be renewed at the same time the registered nurse license is renewed.

(3) The five (5) contact hours may count toward the required contact hours of continuing education for renewal of the registered nurse license.

(4) Failure to meet the five (5) contact hour continuing education requirement shall cause the SANE credential to lapse.

Section 9. Reinstatement. (1) If the SANE credential has lapsed for a period of less than four (4) consecutive registered nurse licensure periods, and the individual wants the credential reinstated, the individual shall apply to[may] reinstate the credential by:

(a) Submitting the Sexual Assault Nurse Examiner Application for Credential["Application for SANE Credential"];

(b) Paying the fee established in 201 KAR 20:240;

(c) Submitting evidence of earning the continuing education requirement for the number of registered nurse licensure periods since the SANE credential lapsed;

(d) Providing a completed Federal Bureau of Investigation (FBI) Applicant Fingerprint Card and paying the fee required by the FBI that is within six (6) months of the date of the application;

(e) Providing 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;

(f) Providing a certified copy of the court record of any misdemeanor or felony conviction as required by 201 KAR 20:370, Section 1(3); and

(g) Providing a letter of explanation that addresses each conviction, if applicable.

(2) An applicant shall not be credentialed until a report is received from the FBI pursuant to the request submitted under subsection (1)(d) of this section and any conviction is addressed by the board.

(3) If the SANE credential has lapsed for more than four (4) consecutive licensure periods, the nurse shall complete a SANE course prior to reinstatement.

Section 10. The board shall obtain input from the Sexual Assault Response Team Advisory Committee concerning any proposed amendment to this administrative regulation as follows:

(1) The board shall send a draft copy of any proposed amendment to the co-chairs of the Sexual Assault Response Team Advisory Committee prior to adoption by the board;

(2) The board shall request that comments on the proposed amendment be forwarded to the board's designated staff person within ninety (90) days; and

(3) At the conclusion of that time period or upon receipt of comments, whichever is sooner, the board, at its next regularly-scheduled meeting, shall consider the comments.

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

(a) "Application for Initial or Continued SANE Course Approval", 2/2014[6/97], Kentucky Board of Nursing;

(b) "Sexual Assault Nurse Examiner Application for Credential", 2/2014[6/2010], Kentucky Board of Nursing;

(c) "SANE Renewal Application", 6/2012, Kentucky Board of Nursing; and

(d) "Annual Credential Renewal Application: SANE with RN Compact License (Not Kentucky)", 2/2014[~~6/2012~~], Kentucky Board of Nursing.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Board of Nursing, 312 Whittington Parkway, Suite 300, Louisville, Kentucky 40222-5172, Monday through Friday, 8:30 a.m. to 4:30 p.m.

SALLY BAXTER, President

APPROVED BY AGENCY: February 21, 2014

FILE WITH LRC: April 11, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 27, 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 five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business, June 2, 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 Sexual Assault Nurse Examiner (SANE) programs and credentials.

(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 has several KRS 13A housekeeping changes and updates several application forms.

(b) The necessity of the amendment to this administrative regulation: Questions concerning criminal and disciplinary history were confusing to applicants. Language was rewritten to be clearer.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to create application forms.

(d) How the amendment will assist in the effective administration of the statutes: By updating the regulation and the application forms.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Applicants for licensure as a SANE, 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: Applicants will use the new forms.

(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.

(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:

GENERAL GOVERNMENT CABINET
Board of Nursing
(Amendment)

201 KAR 20:450. Alternative program.

RELATES TO: KRS 314.085, 314.091, 314.171, 314.470,

STATUTORY AUTHORITY: KRS 314.131(1), (2), 314.171(3)

NECESSITY, FUNCTION AND CONFORMITY: KRS 314.171 authorizes the board to establish an impaired nurses committee to promote early identification, intervention, treatment, and rehabilitation of nurses who may be impaired by reason of illness, alcohol or drug abuse, or as a result of any physical or mental condition. This administrative regulation provides procedures for the implementation of an alternative program.

Section 1. Definitions. (1) "Approved treatment provider" means an alcohol or drug treatment provider that meets the standards as set out in Section 7 of this administrative regulation.

(2) "Board" means the Board of Nursing.

(3)[~~"Chemically-dependent individual" means a person whose ability to practice nursing according to acceptable and prevailing standards of care is or may be impaired by reason of alcohol or drug abuse. (4)~~] "Program" means the Kentucky Alternative Recovery Effort for Nurses which is the alternative program operated by the board for nurses.

(4) "Substance use disorder" means the combined DSM-IV categories of substance abuse and substance dependence.

Section 2. Admission and Denial to the Program. (1) In order to gain admission to the program, an individual shall:

(a) Be an advanced practice registered nurse, a registered nurse, or a licensed practical nurse licensed in the Commonwealth of Kentucky, a holder of a multistate licensure privilege pursuant to KRS 314.470, or an applicant for a credential issued by the board;

(b) Request in writing participation in the program;

(c) Admit in writing to having[~~being~~] a substance use disorder[~~chemically-dependent individual~~];

(d) Agree in writing to the terms set forth in the program agreement;

(e) Obtain a current substance use disorder[~~chemical dependency~~] assessment, which may include a complete physical and psychosocial evaluation performed by a licensed or certified medical, mental health or psychological specialist in the field of drug, alcohol, or other substance use disorder[~~chemical dependency~~];

(f) Provide any evaluation and treatment information, disclosure authorizations, and releases of liability as may be requested by the program staff;

(g) Agree to abide by the programs staff's determination regarding employment as a nurse pending admission; and

(h) Have attended or be enrolled in an approved treatment provider program.

(2) Admission to the program shall be denied if the applicant:

(a) Does not meet the eligibility requirements for admission as set by subsection (1) of this section; or

(b) Is not eligible for licensure in Kentucky or if the board does not grant authorization to practice under KRS 314.470 Article V(f) or 201 KAR 20:500, Section 3(2).

(3) Admission to the program may be denied if the applicant:

(a) Diverted scheduled substances for other than self-administration;

(b) Will not substantially benefit from participation in the program;

(c) Has a criminal conviction related to the sale or distribution of scheduled substances or legend prescription drugs; or

(d) Has been terminated from alternative program participation in Kentucky or any other state.

(4) In the case of an applicant for a credential issued by the board, admission to the program shall be conditioned upon obtaining licensure in Kentucky. Failure to obtain licensure shall result in denial of admission to the program.

Section 3. Requirements for Participation in the Program. (1) A participant shall:

(a) Enter into a program agreement; and

(b) Comply with all of the terms and conditions of the program agreement for the time period specified in the agreement.

(2) The program agreement[~~shall be updated and modified as needed to address the participant's progress in recovery and~~] may include any of the following:

(a) A requirement that the participant undergo and successfully complete substance use disorder[~~chemical dependency~~] treatment by an approved treatment provider;

(b) A requirement that the participant agree not to practice in any capacity in a patient care setting or one which requires licensure until approved to do so by the program;

(c) A requirement that the participant undergo and successfully complete the continuing care program recommended by the approved treatment provider and designated in the program agreement. The continuing care program may include individual or group counseling or psychotherapy;

(d) A requirement that the participant remain free of alcohol, mood-altering substances including herbal preparations, over-the-counter medications containing alcohol or mood-altering substances, and any other medication except for substances prescribed by a practitioner authorized by law to prescribe for a specific medical condition;

(e) A requirement that the participant inform all treating health care practitioners of the participant's substance use disorder[~~chemical dependency~~] and recovery status prior to receiving a prescription for any medication, mood-altering substance, or herbal preparation;

(f) A requirement, if a participant must take any substance prescribed or recommended by a practitioner, that the participant provide the program written documentation from the practitioner that the use of the substance does not impair the participant's ability to practice nursing in a safe and effective manner and will not interfere with the participant's recovery program provided the substance is used in accordance with the prescription or recommendation;

(g) A requirement that if the participant is prescribed, recommended, or dispensed any medication by a practitioner, the participant shall cause the practitioner to report the medication to the program. The report shall include the diagnosis, the name of the medication, the quantity prescribed, any refills or any other information about the medication requested by the program staff, and shall be submitted to the program within the time specified in the program agreement. Consultation with a physician addictionologist may be required by the program and the participant shall agree to abide by any determination made by the physician addictionologist;

(h) A requirement that the participant cause all treatment providers and counselors to provide any reports as may be required by the program at the intervals specified in the program agreement;

(i) A requirement that the participant submit to random alcohol and drug testing when requested by the program, and that the participant comply with all requirements of the program concerning random alcohol and drug testing;

(j) A requirement that the participant attend[~~health professionals' support group,~~] twelve (12) step group meetings, or other group meetings as specified by the program agreement, and that the participant verify attendance at these meetings by signature of a group or meeting representative and submit the signatures to the program;

(k) A requirement that the participant comply with the employment and nursing practice restrictions specified by the program agreement;

(l) A requirement that the participant sign a waiver which would allow the program to communicate with the participant's treatment providers, counselors, employers, work site monitors, law enforcement officials, and[~~health professionals'~~] support group facilitators, if applicable;

(m) A requirement that the participant be responsible for paying the costs of the physical and psychosocial assessment, substance use disorder[~~chemical dependency~~] treatment, and random alcohol and drug testing, or any other costs incurred in complying with the program agreement;

(n) A requirement that the participant submit a written personal report to the program at the intervals specified by the program agreement;

(o) A requirement that the participant meet in person with a program representative at the intervals specified by the program agreement;

(p) A requirement that the participant shall not work as a nurse in another Nurse Licensure Compact state without the permission of this state and the other state; and

(q) A requirement that the participant comply with all other terms and conditions specified in the program agreement which the program staff determines are necessary to ensure that the participant is able to practice nursing in accordance with

acceptable and prevailing standards of safe nursing care.[~~(3)(a) By participating in the alternative program, the participant waives all rights to a hearing on any underlying complaint or any decision to terminate the participant from the alternative program pursuant to Section 5 of this administrative regulation, as well as any right to appeal that decision.~~

~~(b) The participant shall acknowledge in writing his or her understanding and consent to paragraph (a) of this subsection.~~]

Section 4. Successful Completion of the Program. (1) A participant successfully completes the program when the participant fully complies with all of the terms of the program agreement for the period as specified in the agreement.

(2) When a participant successfully completes the program, the program shall notify the participant of the successful completion in writing. Once the participant receives this written notification of successful completion of the program, the participant shall no longer be required to comply with the program agreement.

(3) A participant who successfully completes the program shall not be reported to the National Council of State Boards of Nursing's disciplinary data bank.

Section 5. Causes for Termination from the Program. A participant may be terminated from the program for the following causes:

(1) Noncompliance with any aspect of the program agreement; or

(2)[~~Receipt of information by the board which, after investigation, results in disciplinary action by the board other than a reprimand; or (3)~~] Being unable to practice according to acceptable and prevailing standards of safe nursing care.

Section 6. Resignation From the Program. (1) A participant may resign from the program.

(2) Upon resignation, the participant shall sign an agreed order in conformity to 201 KAR 20:161, Section 2(4) voluntarily surrendering the nursing license.

Section 7. Standards for Approved Treatment Providers. In order to be an approved treatment provider, the treatment provider shall:

(1) Be:

(a) Accredited by the Joint Commission for the Accreditation of Healthcare Organizations or be state-certified and shall have operated as a substance use disorder[~~chemical dependency~~] treatment program for a minimum of one (1) year; or

(b) A licensed or certified specialist in the field of substance use disorder[~~chemical dependency~~] treatment as outlined in 201 KAR 20:163, Section 2(2);

(2) Provide inpatient or outpatient care;

(3) Be based on a twelve (12) step program of Alcoholics Anonymous/Narcotics Anonymous or equivalent support group;

(4) Provide development of an individualized treatment and aftercare program to meet the specific needs of the participant and make recommendations regarding an ongoing rehabilitation plan;

(5) Be based on an evaluation that meets the standards of 201 KAR 20:163, Section 3;

(6) Provide clearly-stated costs and fees for services, and offer fee schedules and flexibility in payment plans to accommodate participants who are underinsured or experiencing financial difficulties;

(7) Demonstrate willingness to provide information to the alternative program regarding the status of the participant after appropriate consents to release information are obtained;

(8) Work closely with the alternative program staff to assure proper implementation and administration of policies and procedures related to the program;

(9) Maintain timely and accurate communication with program staff, including assessments, diagnosis, prognosis, discharge summary and follow-up recommendations as well as reports on significant events which occur in treatment that are related to impairment and the ability to practice safely; and

(10) Provide written reports of progress at intervals as requested by program staff.

Section 8. An individual who is admitted to the program but does not hold a Kentucky nursing license shall pay a participation fee of fifty (50) dollars per year.

Section 9. (1) A participant in the alternative program who moves to another jurisdiction may transfer to the new jurisdiction's alternative program.

(2) If the participant is accepted into the new jurisdiction's alternative program, the participant may relinquish his or her Kentucky license pursuant to 201 KAR 20:510.

(3) The provisions of Section 6 of this administrative regulation shall not apply in this situation.

(4) If the participant relinquishes his or her Kentucky license, the alternative program in Kentucky shall cease monitoring the participant.

Sally Baxter, President

APPROVED BY AGENCY: April 10, 2014

FILED WITH LRC: April 11, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 27, 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 May 20, 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 close of business June 2, 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 the procedures for the Board's alternative to discipline program.

(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 procedures.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: By setting procedures.

(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 makes several housekeeping changes, primarily replacing chemical dependency with substance use disorder.

(b) The necessity of the amendment to this administrative regulation: The regulation requires periodic updating and the accepted terminology has changed.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to set these matters.

(d) How the amendment will assist in the effective administration of the statutes: By updating the procedures.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Nurses admitted into the alternative program, number unknown (presently there are approximately

200).

(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 follow the new procedures.

(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 new cost.

(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:

GENERAL GOVERNMENT CABINET
Kentucky Board of Physical Therapy
(Amendment)

201 KAR 22:040. Procedure for renewal or reinstatement of a credential for a physical therapist or a physical therapist assistant.

RELATES TO: KRS 164.772, 214.610(1), 327.050(8), (9), 327.070

STATUTORY AUTHORITY: KRS 327.040(10), (11)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 327.040(11) authorizes the board to promulgate administrative regulations for the effectuation of the purposes of KRS Chapter 327, and 327.040(10) authorizes the board to promulgate administrative regulations establishing a measure of continued competency as a condition of license renewal. This administrative regulation establishes the requirements and procedures for the renewal and reinstatement of credentials.

Section 1. A credential shall be renewed upon:

(1) Payment of the renewal fee established in 201 KAR 22:135 on or before March 31st of each uneven numbered year. The fee shall be waived for renewal of license or certificate held by active duty member of Armed Forces as set forth in KRS 12.355;

(2) Submission of the completed Renewal or Reinstatement Application;

(3) Verification of continued competence as set forth in 201 KAR 22:045;

(4) In accordance with the course requirement in KRS 327.050(8), verification of completion of a Cabinet for Health Services (CHS) approved two (2) hour course on the transmission, control, treatment and prevention of human immunodeficiency virus infection and AIDS, pursuant to KRS 214.610(1) but not more than every ten (10) years. The course shall be completed within the renewal biennial period that it is due; and

(5) Verification that, since the last renewal period, the credential holder has not:

(a) Been in violation of KRS 327.070;

(b) Had a professional license or credential disciplined or under current disciplinary review in this state or another jurisdiction;

(c) Had a civil claim made against the credential holder which related to the credential holder's practice of physical therapy; or

(d) Defaulted on the repayment obligation of financial aid programs administered by the Kentucky Higher Education Assistance Authority (KHEAA) per KRS 164.772.

Section 2. Credentials not renewed by the board by March 31 of each uneven numbered year shall lapse.

Section 3. A credential holder who has a credential that has lapsed less than three (3) years may reinstate upon:

(1) Meeting the requirements of Section 1(2), (4), and[~~through~~] (5) of this administrative regulation for the current renewal period;

(2) Verification of having obtained within two (2) years prior to the date of submission of the completed Renewal or Reinstatement Application:

(a) Thirty (30) hours of continued competency as set forth in 201 KAR 22:045, Section 2(1)(a)1, 2, and 3 and (c) for a physical therapist; or

(b) Twenty (20) hours of continued competency as set forth in 201 KAR 22:045, Section 2(1)(b)1, 2 and 3 and (c) for a physical therapist assistant.

(3) Continued competency hours submitted under subsection (2) of this section for reinstatement shall satisfy the continued competency hours for the next renewal period as set forth in 201 KAR 22:045, Section 2(2) and (3).

(4)[~~and (2)~~] Submission of payment of the reinstatement fee established in 201 KAR 22:135.

Section 4. A credential holder who has a credential that has lapsed greater than three (3) years may reinstate upon:

(1) Meeting the requirements of Section 3 ;

(2) Submission of all credentials from other jurisdictions since last renewal; and

(3) If not holding a current credential from any other jurisdiction since last renewal, the board shall require the following:

(a) Submission of evidence of professional competency;

(b) An agreement to practice physical therapy under direct supervision not to exceed six (6) months;

(c) Successful completion of the board-approved examination; or

(d) Any combination of paragraphs (a) through (c) of this subsection.

Section 5. Incorporation by Reference. (1) "Renewal or Reinstatement Application", June 2012, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Board of Physical Therapy, 312 Whittington Parkway, Suite 102, Louisville, Kentucky 40222, Monday through Friday, 8 a.m. to 4:30 p.m.

SCOTT D. MAJORS, Executive Director

APPROVED BY AGENCY: April 14, 2014

FILED WITH LRC: April 15, 2014 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 30, 2014, at 4:00 p.m. (EST) at 312 Whittington Parkway, Suite 102, Louisville, Kentucky 40222. 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 close of business, June 2, 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: Scott D. Majors, Executive Director, Board of Physical Therapy, 312 Whittington Parkway, Suite 102, Louisville, Kentucky 40222, phone (502) 429-7140, fax (502) 429-7142.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Scott D. Majors

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the procedure for renewal or reinstatement of a credential of a physical therapist or a physical therapist assistant.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to implement provisions of KRS 327.040(10) and (11).

(c) How this administrative regulation conforms to the content of the authorizing statutes: It provides the procedures for renewal or reinstatement of a license or certificate to practice physical therapy in the Commonwealth of Kentucky.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It provides the procedures for renewal or reinstatement of a license or certificate to practice physical therapy in the Commonwealth of 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 clarifies the number of continued competency hours and the period of time in which the continued competency hours may be earned in order to reinstate a license or certificate.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure that there is a defined number of continued competency hours earned within a period of time in order to reinstate a license or certificate.

(c) How the amendment conforms to the content of the authorizing statutes: The board is authorized to set the procedures for renewal or reinstatement of a license or certificate to practice physical therapy in Kentucky.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will ensure the board is protecting the public by establishing the procedures for renewal or reinstatement of a license or certificate to practice physical therapy in Kentucky.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This amendment will affect no more than approximately 100 licensed physical therapists or certified physical therapist assistants per year who apply to the board to reinstate their credential to practice physical therapy in the Commonwealth of 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: The entities in (3) will be required to meet the standards of this amendment to be eligible for the reinstatement of their licensed or certificate to practice physical therapy.

(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 minimal cost to the entities in questions (3) since current procedures for the reinstatement of a license or certificate to practice physical therapy already require proof of continued competency hours.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Protect the health and welfare of the public with regard to the provision of physical therapy by those persons who reinstate a license or a certificate.

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

(a) Initially: No costs to the board.

(b) On a continuing basis: No costs to the board.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: N/A to Agency Revenue 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: There will be no 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 change the fees directly or indirectly.

(9) Tiering: Is tiering applied? Yes, tiering was used. While the renewal provisions apply equally to all persons who hold a license or certificate to practice physical therapy, this administrative regulation has separate requirements for the reinstatement of a license or certificate to practice physical therapy based on whether the person has had a lapsed license or certificate less than three (3) years or more than three (3) years as set forth by KRS 327.075(1) and (2).

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? Physical therapists and physical therapists assistants credentialed by the Board.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 327.040 and KRS 327.050.

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. No effect.

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

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

(c) How much will it cost to administer this program for the first year? None.

(d) How much will it cost to administer this program for subsequent years? None.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET
Kentucky Board of Social Work
(Amendment)

201 KAR 23:015. Temporary permission to practice.

RELATES TO: KRS 335.080, 335.090, 335.100

STATUTORY AUTHORITY: KRS 335.070(1), (3), (9)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 335.070(1) requires the board to evaluate and approve the qualifications of applicants for licensure. KRS 335.070(3) authorizes the board to promulgate administrative regulations. KRS 335.070(9) authorizes the board to establish requirements for temporary permits to practice social work. This administrative regulation establishes the requirements for the granting of temporary permission to engage in the practice of social work.

Section 1. (1) A temporary permit to engage in the practice of social work shall be granted, if requested, to an applicant who has completed all of the requirements for licensure except the examination and has applied for licensure under the provisions of KRS 335.080, 335.090, or 335.100.

(2) A person practicing under a temporary permit as a certified social worker shall not accumulate hours towards the supervision requirements of KRS 335.100(1)(b).

(3) Certified social workers and licensed clinical social workers practicing clinical social work under a temporary permit shall be under the supervision of a licensed clinical social worker who qualifies to provide supervision under 201 KAR 23:070, Section 3(1)[~~, or equivalent~~].

(4) The request for a temporary permit shall be accompanied by a letter from the proposed supervisor acknowledging the responsibility for supervision and for the practice of the person holding the temporary permit.

(5) A licensee shall not serve as the supervisor for more than two (2) persons holding a temporary permit at any one (1) time.

(6) Supervision during the period of temporary permission to practice shall be a minimum of one (1) hour of individual, face-to-face supervision per week.

(7) The temporary permit shall be valid until the applicant for licensure is issued or denied licensure under the provisions of KRS 335.080, 335.090, or 335.100, but the temporary permit shall not extend for more than 240 days after the temporary permit was approved[~~applicant has applied for licensure~~].

(8) Any changes of the terms of the temporary permit shall be submitted to the board and approved by the board before the temporary permit holder continues social work practice[~~More than one (1) temporary permit shall not be granted for any applicant for licensure~~].

SHARON SANDERS, Chair

APPROVED BY AGENCY: March 14, 2014

FILED WITH LRC: March 14, 2014 at 4 p.m.

PUBLIC HEARING: A public hearing on this administrative regulation shall be held on May 30, 2014 at 1:00 p.m., at 44 Fountain Place, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by May 23, 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 attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until June 2, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Margaret Hazlette, Executive Director, Kentucky Board of Social Work, 44 Fountain Place, Frankfort, Kentucky 40061, phone (502) 564-2350, fax (502) 696-8030.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Margaret Hazlette

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the standards for obtaining a temporary permit from the board to allow an applicant to practice social work while taking the requisite examination for licensure.

(b) The necessity of this administrative regulation: This regulation is necessary to identify the requirements for a temporary permit.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity as the authorizing statute gives the board the ability to promulgate regulations for a temporary permit.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will assist the board in administering this program.

(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 identifies how long a temporary permit lasts, who can be a supervisor, and the requirements for changes to the temporary permit.

(b) The necessity of the amendment to this administrative regulation: This is amendment is necessary to administer the temporary permit process.

(c) How the amendment conforms to the content of the authorizing statutes: The authorizing statues allow the board to set the requirements for a temporary permit.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the statutes by identifying how long a temporary permit lasts, who can be a supervisor, and the requirements for changes to the temporary permit.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The administrative regulation affects persons who apply for a license but who not taken the examination. It allows them to practice under a temporary permit while they take the examination. The board issues approximately thirty (30) a 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: Persons who are applying for licensure will be required to comply with this regulation.

(b) In complying with this administrative regulation or

amendment, how much will it cost each of the entities identified in question (3): No known costs are involved in the compliance with this regulation.

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

(a) Initially: No known costs are involved in the implementation of this regulation.

(b) On a continuing basis: See paragraph (5)(a).

(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: An increase in fees will not be required to implement the requirements established in this 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 fees directly or indirectly increase fees.

(9) TIERING: Is tiering applied? Tiering was not applied by the board.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Kentucky Board of Social Work.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 335.070.

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

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

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

(c) How much will it cost to administer this program for the first year? None.

(d) How much will it cost to administer this program for subsequent years? None.

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 2:300. Black bear seasons and requirements.

RELATES TO: KRS 150.010, 150.092, 150.170, 150.175, 150.990

STATUTORY AUTHORITY: KRS 150.025(1), 150.390(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 150.025(1) authorizes the department to promulgate administrative regulations to establish open seasons for the taking of wildlife, to regulate bag limits and methods of take, and to make these requirements apply to a limited area. KRS 150.390(1) prohibits the taking of bears in any manner contrary to any provisions of KRS Chapter 150 or its administrative regulations. This administrative regulation establishes bear hunting and chasing seasons; bear hunting areas; legal methods of take; and permitting, checking, and recording requirements.

Section 1. Definitions. (1) "Adult" means an individual who is at least eighteen (18) years of age.

(2) "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.

(3) "Arrow" means the projectile fired from a bow or crossbow.

(4) "Baited area" means an area where feed, grains, or other substances capable of luring black bears have been placed.

(5) "Barbed broadhead" means a point or portion of a blade projecting backward from a broadhead designed to hold an arrow within an animal.

(6) "Bear" means the species Ursus americanus.

(7) "Bear chase area" means a designated area within the Bear Zone where hunters may use dogs to chase bears.

(8) "Bear chase permit" means a permit, which in conjunction with appropriate licenses, seasons, and methods, allows the holder to use dogs to chase a bear.

(9) "Bear permit" means a permit, which in conjunction with appropriate licenses, seasons, and methods, allows the holder to take one (1) black bear of either sex.

(10) "Bear zone" means the following Kentucky counties: Bell, Clay, Floyd, Harlan, Knott, Knox, Laurel, Leslie, Letcher, Martin, McCreary, Perry, Pike, Pulaski, Wayne, and Whitley.

(11) "Chase-only season" means a designated season when a person may use dogs to chase a bear, without killing or intentionally injuring a bear.

(12) "Crossbow" means a bow designed or fitted with a device to hold an arrow at full or partial draw without aid from the archer.

(13) "Firearm" means a breech or muzzle-loading rifle, shotgun, or handgun.

(14)[~~"Fully-automatic firearm" means a firearm which fires more than one (1) time with a single pull from the trigger. (15)~~] "Junior bear chase permit" means a permit, which in conjunction with appropriate licenses, seasons, and methods, allows a youth to use dogs to chase a bear.

(15)[~~(16)~~] "License year" means the period from March 1 through the following last day of February.

(16)[~~(17)~~] "Modern gun" means a rifle, handgun, or shotgun loaded from the rear of the barrel.

(17)[~~(18)~~] "Muzzle-loading firearm" means a rifle, shotgun, or handgun loaded from the discharging end of the barrel or discharging end of the receiver.

(18)[~~(19) "Shotshell" means ammunition discharged from a shotgun. (20)~~] "Youth" means a person under the age of sixteen (16) by the day of the hunt.

Section 2. Feeding Black Bears. A person shall not engage in any direct or indirect feeding of black bears.

Section 3. Bear Chase Requirements. (1) A person shall first obtain the appropriate bear chase permit from the department before chasing bears.

(2) A bear chase permit or junior bear chase permit shall only be purchased by a resident of Kentucky.

(3) Unless exempted by KRS 150.170, a person shall carry proof of purchase of a valid Kentucky hunting license and valid bear chase permit while using dogs to chase bears.

(4) A bear chase permit shall[~~permits may~~] be purchased on the department's Web site at fw.ky.gov from July 1 through December[~~August~~] 31.

(5) A person shall not:

(a) Kill or intentionally injure a bear during a chase-only season;

(b) Chase a bear except during daylight hours while a chase season is open;

(c) Chase a bear from a baited area:

1. While bait is present; or

2. For thirty (30) days after the bait has been removed; or

(d) Disturb a bear in a den.

(6) Individual hunt groups shall include no more than five (5)

people and eight (8) dogs, except:

(a) A hunt party may total seven (7) people if two (2) additional youths accompany the party;

(b) The two (2) additional youths do not have to be drawn as part of a quota hunt party; and

(c) The two (2) additional youths shall not be allowed to harvest a bear.

(7) Any dog transported in a motorized vehicle by members of a hunt group shall be considered a member of that hunt group.

(8) The department shall supply a bear chase survey to each person purchasing a bear chase permit.

(9) A person who purchases a bear chase permit shall submit to the department a completed bear chase survey by the last day of January following each bear season.

(10) A person who fails to submit a bear chase survey shall be ineligible to purchase a bear chase permit for the following year's chase seasons.

(11) A person shall only use a dog to chase a bear in the following designated areas:

(a) Eastern bear chase area;

(b) Central bear chase area; and

(c) Western bear chase area.

Section 4. Chasing Bears with Dogs. A person shall not use a dog to chase a bear except during the following seasons:

(1) The chase-only season, which shall be from August 1 through August 31; and

(2) The bear quota hunt with dogs season pursuant to Section 8 of this administrative regulation.

Section 5. Bear Permit Requirements. (1) Only a resident of Kentucky shall be allowed to purchase a bear permit.

(2) Unless exempted by KRS 150.170, a person hunting a bear shall possess proof of purchase of a valid Kentucky hunting license and valid bear permit while hunting.

Section 6. Hunter Restrictions. (1) A person shall not:

(a) Harvest a bear except during daylight hours;

(b) Use dogs during the modern gun[~~regular bear hunting~~] season for bears, except leashed tracking dogs may be used to recover a wounded or dead bear[~~bears~~];

(c) Hunt bear on a baited area:

1. While bait is present; or

2. For thirty (30) days after the bait has been removed;

(d) Harvest:

1. A female bear that has a cub; or

2. A bear that weighs less than seventy-five (75) pounds;

(e) Harvest a bear that is swimming;

(f) Harvest a bear if the person is in a vehicle, boat, or on horseback, except that a hunter in possession of a disabled hunting exemption permit issued by the department may use a stationary vehicle as a hunting platform;

(g) Harvest a bear in a den; or

(h) Disturb a bear in a den for the purpose of taking the bear if the bear exits the den.

(2) An adult shall accompany and maintain control of a youth who is hunting bear with a firearm.

Section 7. Weapon Restrictions. (1) A person shall only use the weapons and ammunition established in paragraphs (a) through (e) of this subsection to take a bear:

(a) A crossbow or archery equipment loaded with a non-barbed broadhead of seven-eighths (7/8) inch or wider upon expansion;

(b) A firearm:

1. With an action that fires a single round of ammunition upon each manipulation of the trigger;

2. Of .270 caliber or larger; and

3. Loaded with centerfire, single projectile ammunition designed to expand upon impact;

(c) A muzzle-loading firearm of .50 caliber or larger;

(d) A shotgun of twenty (20) gauge or larger loaded with a shell containing one (1) projectile; or

(e) A handgun loaded with:

1. Centerfire cartridges;

2. Bullets of .270 caliber or larger designed to expand upon impact; and

3. Cartridges with a case length of 1.285 inches or larger.

(2) A crossbow shall contain a working safety device.

(3) A bear hunter shall not use a magazine capable of holding more than ten (10) rounds[~~A person shall not use the following to take a bear:~~

~~(a) A device capable of taking a bear other than a firearm, crossbow, or archery equipment;~~

~~(b) A modern firearm less than .270 caliber;~~

~~(c) A muzzle-loading firearm less than .50 caliber;~~

~~(d) A shotgun less than twenty (20) gauge;~~

~~(e) Rimfire ammunition;~~

~~(f) A fully-automatic firearm;~~

~~(g) A firearm with a magazine capacity greater than ten (10) rounds;~~

~~(h) Steel-jacketed ammunition;~~

~~(i) Tracer bullet ammunition;~~

~~(j) A shotshell containing more than one (1) projectile;~~

~~(k) A broadhead smaller than seven-eighths (7/8) inch wide;~~

~~(l) A barbed broadhead;~~

~~(m) A crossbow without a working safety device;~~

~~(n) A chemically treated arrow; or~~

~~(o) An arrow with a chemical attachment.~~

~~(2) A bear shall not be taken with a handgun that does not:~~

~~(a) Have a barrel length of at least six (6) inches;~~

~~(b) Have a bore diameter of at least 0.270 inches; or~~

~~(c) Fire a bullet that produces at least 550 ft/lbs of energy at 100 yards~~].

Section 8. Bear Season Dates and Bag Limits. (1) A legal bear hunter shall only kill a bear in the bear zone during the[~~following~~] seasons established in paragraphs (a) through (c) of this subsection:

(a) The archery – crossbow season for bears, which shall be for nine (9) consecutive days beginning on the Saturday before Thanksgiving;

(b) The modern gun[~~regular bear~~] season for bears, which shall be for three (3) consecutive days beginning on the second Saturday in December; and

(c) The bear quota hunt with dogs season, which shall be for five (5) consecutive days beginning on the Monday following the modern gun[~~regular bear~~] season for bears.

(2) A person shall not take more than one (1) bear in a license year.

(3) A hunt party drawn for the bear quota hunt with dogs season shall not take more than one (1) bear in a license year.

Section 9. Bear Season Closure. (1) The archery - crossbow season for bears shall close after daylight hours on the day the following quota has been reached:

(a) Ten (10) bears; or

(b) Five (5) female bears.

(2) The modern gun[~~regular bear~~] season for bears shall close after daylight hours on the day the following quota has been reached:

(a) Ten (10) bears; or

(b) Five (5) female bears.

(3) The bear quota hunt with dogs season shall close after daylight hours on the day the quota of five (5) bears has been reached.

(4) A bear hunter shall call 800-858-1549 after 9 p.m. each day of any open bear season to determine if the annual quota has been reached.

Section 10. Bear Quota Hunt with Dogs Requirements. (1) A person shall apply for the quota hunt on the department's Web site at fw.ky.gov from September 1 through September 30.

(2) An applicant shall possess a bear chase permit before applying.

(3) A person shall not:

(a) Apply more than one (1) time;

(b) Apply as a party of more than five (5) people; or

(c) Be eligible to take a bear unless drawn by the department in the bear quota hunt lottery.

(4) A person shall only harvest a bear with the use of unleashed dogs.

(5) A person or each member of a hunt party selected for the quota hunt shall possess a bear permit in order to kill a bear.

(6) The bear quota hunt with dogs season shall also be open as a chase-only season for any person who possesses a valid bear chase permit.

Section 11. Hunter Orange Clothing Requirements. (1) During any modern gun or muzzle-loading season for bears, a person hunting any species, and any person accompanying a hunter, shall display solid, unbroken hunter orange visible from all sides on the head, back, and chest, except these requirements shall not apply to a person hunting:

(a) Waterfowl; or

(b) Furbearers at night during a legal furbearer season.

(2) 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.

Section 12. Bear Reserves. (1) The[~~following~~] areas within the Bear Zone established in paragraphs (a) through (d) of this subsection shall be closed to bear hunting:

(a) Cumberland Gap National Historical Park;

(b) Hensley-Pine Mountain Wildlife Management Area;

(c) Big South Fork National River and Recreation Area; and

(d) The area surrounding Hensley-Pine Mountain Wildlife Management Area: starting at the intersection of Sand Hill Bottom Road and North US Hwy 119 in Cumberland, the boundary proceeds northeast along North US Hwy 119 to the intersection of US Hwy 119 and Kentucky Hwy 2035. The boundary then proceeds west along Kentucky Hwy 2035 to the intersection of Kentucky Hwy 2035 and Kentucky Hwy 931. The boundary continues southwest along Kentucky Hwy 931 to the intersection of Kentucky Hwy 931 and Kentucky Hwy 160, then proceeds southwest along Kentucky Hwy 160 to the intersection of Kentucky Hwy 160 and Kentucky Hwy 463 in Gordon. The boundary then proceeds south and east along Kentucky Hwy 160 to the intersection of Kentucky Hwy 160 and Sand Hill Bottom Road in Cumberland, then south along Sand Hill Bottom Road to the intersection with North US Hwy 119, completing the boundary.

(2) Kentucky resident landowners, their spouses, and dependent children may hunt bears on their own property within the closed area established[~~referenced~~] in subsection (1)(d) of this section.

Section 13. Harvest Recording and Check-in Requirements. (1) Immediately after harvesting a bear, and before moving the carcass, a person shall record on a hunter's log the:

(a) Species taken;

(b) Date taken;

(c) County where taken; and

(d) Sex of the bear.

(2) A person who has harvested a bear during the modern gun[~~regular bear~~] season for bears shall:

(a) Retain a completed hunter's log;

(b) Check a harvested bear at a department-operated check station immediately after leaving the field;

(c) Telecheck the bear before leaving the check station by:

1. Calling 800-245-4263 and completing the telecheck process or checking the bear on the department's Web site at fw.ky.gov; and

2. Recording the confirmation number on the hunter's log; and

(d) Attach to the carcass a department issued tag prior to leaving the check station.

(3) A person who has harvested a bear during the archery – crossbow season or the bear quota hunt with dogs season shall:

(a) Retain a completed hunter's log;

(b) Telecheck the bear by 8 p.m. Eastern Standard Time the day the bear was harvested by:

1. Calling 800-245-4263 and completing the telecheck process or checking the bear on the department's Web site at fw.ky.gov; and

2. Recording the confirmation number on the hunter's log;

(c) Arrange for department personnel to inspect the bear by:

1. Calling the department at 800-858-1549[~~or 800-252-5378~~] within twenty-four (24) hours of harvest; and

2. Presenting to department personnel the bear carcass or an intact hide that contains the skull and proof of sex; and

(d) Attach to the carcass a department issued tag after having the bear inspected by department personnel.

Section 14. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Eastern Bear Chase Area" map, 2013 edition;

(b) "Central Bear Chase Area" map, 2013 edition;[~~and~~]

(c) "Western Bear Chase Area" map, 2013 edition;

(d) "20__ Bear Chase Survey", 2014 edition; and

(e) "Bear Quota Hunt With Dogs Application", 2014 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Fish and Wildlife Resources, #1 Sportsman's Lane, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time.

MATT SAWYERS, Acting Commissioner
ROBERT H. STEWART, Secretary

APPROVED BY AGENCY: April 9, 2014

FILED WITH LRC: April 14, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 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 by five business days prior to the hearing of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation by close of business June 2, 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 black bear chase and hunt seasons, chase and hunt requirements, bag limits, and legal methods of take.

(b) The necessity of this administrative regulation: To establish bear hunting season requirements and methods of take to provide reasonable hunting and chasing opportunity, while properly managing bear populations in Kentucky.

(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 to establish open seasons for the taking of wildlife, regulate bag limits, and to make these requirements apply to a limited area. KRS 150.390(1) prohibits the taking of bears 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 administering the above statutes by defining the seasons, bag limits, and methods of chase and take used to manage black bears 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 will expand the time in which a person may purchase a bear chase permit from July 1 – August 31 to July 1 – December 31. This amendment also changes the name of the "regular bear season" to the "modern gun season for bears". Additionally, this regulatory change amends the weapon restrictions section to detail weapons that a person "shall only" use when hunting bears, as opposed to weapons that a person "shall not" use. In doing so, this amendment maintains existing weapon restrictions while also now prohibiting the use of air guns for the take of black bears. Lastly, amendments to the weapon restrictions section place new restrictions on handguns that may be used to take bears.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to increase opportunity for persons participating in the December bear quota hunt with dogs by extending the period in which bear chase permits may be purchased. Changing the name of the "regular bear season", in which modern firearms may be used, to the "modern gun season for bears" more clearly distinguishes it from the November archery-crossbow season for bears that was established in 2013. The amendment to detail weapons that a person "shall only" use serves to more clearly define legal weapons and prohibit insufficient weapons that are not addressed by the existing regulatory language (i.e., air guns and arrows not equipped with a broadhead). Lastly, new restrictions on handguns creates language that is more enforceable to law enforcement officers by establishing standard metric restrictions for bullet caliber and cartridge case length that can be measured in the field. Likewise, this amendment removes the existing minimum barrel length for handguns as that restriction is overly restrictive to hunters.

(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 hunters that pursue black bears will be affected by this regulatory amendment. In 2013, there were 707 Bear Permits, 17 Bear Chase Permits, and 2 Junior Bear Chase permits sold 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: Those who hunt bears must comply with the individual requirements and restrictions for respective hunt or chase-only seasons for bears, as listed in the fall hunting guide published 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): This amendment does not modify the costs of bear hunt and chase permits.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): More opportunity will be generated for participation in the December bear quota hunt with dogs because bear chase permits will now be available for purchase from June 1 – December 31; previously these permits were only available for purchase through August 31. Newly proposed weapon restrictions more clearly define legal weapon types and establish restrictions on handguns that are less restrictive.

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

(a) Initially: There will be no administrative cost to the department to implement this regulation.

(b) On a continuing basis: There will be no cost to the department on a continuing basis.

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

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

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: No fees established or increased.

(9) TIERING: Is tiering applied? No. Tiering was not used because all persons who hunt bears are required to abide by the same seasons, methods of take, bag limits, harvest recording procedures, and checking 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 of Fish and Wildlife Resources Divisions of Wildlife and Law Enforcement will be impacted by this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 150.025(1) 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? The amount of revenue generated by bear hunt and bear chase permits pursuant to 301 KAR 3:022 was approximately $21,740 in 2013. It is unknown how the amendments to this administrative regulation will affect this number.

(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 amount of revenue generated by this administrative regulation for subsequent years is expected to be stable to slightly increasing.

(c) How much will it cost to administer this program for the first year? There will be a small administrative cost to administer this program for the first year.

(d) How much will it cost to administer this program for subsequent years? There will be a small administrative cost 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 (+/-): None

Expenditures (+/-): None

Other Explanation:

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Kentucky Board of Education
Department of Education
(Amendment)

702 KAR 7:065. Designation of agent to manage middle and high school interscholastic athletics.

RELATES TO: KRS 156.070(2)

STATUTORY AUTHORITY: KRS 156.070(1), (2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 156.070(1) requires the Kentucky Board of Education (KBE) to manage and control the common schools, including interscholastic athletics in the schools. KRS 156.070(2) authorizes the KBE to

designate an agency to manage athletics. This administrative regulation designates an agent for middle and high school athletics; establishes the financial planning and review processes for the agent; and incorporates by reference the bylaws, procedures and rules of the agent.

Section 1. The Kentucky High School Athletic Association (KHSAA) shall be the Kentucky Board of Education's agent to manage interscholastic athletics at the middle and high school level in the common schools, including a private school desiring to associate with KHSAA or to compete with a common school.

Section 2. To remain eligible to maintain the designation as the agent to manage interscholastic high school athletics, the KHSAA shall:

(1) Accept four (4) at-large members appointed by the Kentucky Board of Education to its high school Board of Control;

(2) Sponsor an annual meeting of its member high schools;

(3) Provide for each member high school to have a vote on KHSAA constitution and bylaw changes submitted for consideration;

(4) Provide for high school regional postseason tournament net revenues to be distributed to the member high schools in that region participating in that sport, utilizing a share approach determined by the high schools within that region playing that sport;

(5) Provide for students desiring to participate at the high school level (regardless of level of play) to be enrolled in at least grade seven (7) unless the student has participated at the high school level prior to the 2014 - 2015 school year;

(6) Require its governing body to annually establish goals and objectives for its commissioner and perform a self-assessment and submit the results annually to the KBE by December 31;

(7) Advise the Department of Education of all legal action brought against the KHSAA;

(8) Permit a board of control member to serve a maximum of two (2) consecutive four (4) year terms with no region represented for more than eight (8) consecutive years;

(9) Employ a commissioner and evaluate that person's performance annually by October 31, and establish all staff positions upon recommendation of the commissioner;

(10) Permit the commissioner to employ other personnel necessary to perform the staff responsibilities;

(11) Permit the Board of Control to assess fines on a member high school;

(12) Utilize a trained independent hearing officer instead of an eligibility committee for a high school athletic eligibility appeal;

(13) Establish a philosophical statement of principles to use as a guide in a high school eligibility case;

(14) Conduct continual cycles of field audits of the association's entire high school membership which provides that each high school is audited[~~over a five (5) year period~~] regarding each school's compliance with 20 U.S.C. Section 1681 (Title IX) and submit annual summary reports including the highlighting of any potential deficiencies in OCR compliance to the Kentucky Board of Education;

(15) As a condition precedent to high school membership, require each member high school and superintendent to annually submit a written certification of compliance with 20 U.S.C. Section 1681 (Title IX);

(16) Conduct all meetings related to high school athletics in accordance with KRS 61.805 through 61.850;

(17) Provide written reports of any investigations into possible violations of statute, administrative regulation, KHSAA Constitution, bylaws, and other rules governing the conduct of high school interscholastic athletics conducted by KHSAA or their designees to the superintendent and principal of the involved school district and school prior to being made public; and

(18) Not punish or sanction, in any manner, a school, student, coach, or administrator for allowing a student to play in an athletic contest or practice with the team during a time when an order of a court of competent jurisdiction permits the student to participate or otherwise stays or enjoins enforcement of a KHSAA final decision on eligibility.

Section 3. To remain eligible to maintain the designation as the agent to manage interscholastic athletics at the middle school level, beginning with the 2014-2015 school year, the KHSAA shall implement the following requirements for all participants in middle school athletics and distribute these requirements to all middle schools and publish via the KHSAA Web site:

(1) Require that any coach (head or assistant, paid or unpaid) desiring to coach interscholastic athletics at the middle school level meet the requirements of KRS 156.070(2)(f)2. and KRS 160.380(4) and (6);

(2) Require the adherence to the following items regarding safety, sports medicine, and risk minimization for all interscholastic athletics at the middle school level:

(a) Each student, prior to trying for a place on a middle school athletic team, shall provide an annual medical examination performed and signed by a physician, physician assistant, advanced practice registered nurse, or chiropractor (if performed within the professional's scope of practice), for each student seeking eligibility to participate in any school athletic activity or sport using the form approved for use at the high school level;

(b) All participants at the middle school level shall adhere to all sports medicine policies in use at the middle school level that may be supplemented by the school, school district, conference, or association including:

1. Heat index and heat illness programs;

2. Wrestling weight management programs; and

3. Concussion and other head injury policies;

(3) Create a permanent Middle School Athletics Advisory Committee. This committee shall:

(a) Be autonomous with respect to the Board of Control of the KHSAA;

(b) Be composed of no less than three (3) middle school representatives from each Supreme Court district as well as no less than three (3) at large representatives from throughout the state;

(c) Provide an opportunity for nonprofit athletic groups, parents, and others to participate and provide input on the sport, athletic event, or athletes involved in interscholastic activities through local school districts;

(d) Meet not less than twice annually to review current programs and policies; make recommendations for improvements to and participation in middle school interscholastic activities, as well as any changes in statute, administrative regulation, or policy related to middle school interscholastic athletics; and assist in the development of model guidelines for schools, districts, conferences and associations to be used in implementing a middle school athletic program; and

(e) Report regularly, not less than annually, to the commissioner of the KHSAA and issue, in conjunction with the commissioner, a formal written report annually to the Kentucky Board of Education with recommendations for changes in statute, administrative regulation, or policy;

(4) Require any organization conducting a school based event at the middle school level to submit the following, which shall be published and listed on the KHSAA Web site:

(a) Annual financial reports of all sanctioned and approved events sponsored by the organization; and

(b) Documentation of financial accountability including verification of federal status and tax documents including an annual IRS Form 990;

(5) Provide notice to the middle schools related to any program conducted by KHSAA related to educating school administrators about the provisions of Title IX;

(6) Provide educational materials and a mechanism to facilitate the monitoring and tracking capabilities for the middle schools to ensure compliance with the provisions of KRS 160.445, and other requirements for coaches at the middle school level;

(7) Beginning with the 2015-2016 school year, require any student enrolled initially in grade (5) through eight (8) during the 2015-2016 school year or thereafter who is repeating a grade for any reason, to be ineligible to compete in interscholastic

competition involving students enrolled in grades six (6) through eight (8) while repeating a grade;

(8) Beginning with the 2015-2016 school year, require any student who turns:

(a) Fifteen (15) years of age prior to August 1 of the current school year shall not be eligible for interscholastic athletics in Kentucky in competition against students exclusively enrolled in grades eight (8) and below;

(b) Fourteen (14) years of age prior to August 1 of the current year shall not be eligible for interscholastic athletics in Kentucky in competition against students exclusively enrolled in grades seven (7) and below; and

(c) Thirteen (13) years of age prior to August 1 of the current school year shall not be eligible for interscholastic athletics in Kentucky in competition against students exclusively enrolled in grades six (6) and below;

(9) Require each school, school district, conference, or association of schools to develop rules and limitations regarding student participation at the middle school level to include:

(a) A defined age limitation for participating students;

(b) A policy regarding the participation of students below grade six (6);

(c) A limitation on practice time prior to the season in any sport or sport activity which shall not exceed the practice time adopted for play at the high school level;

(d) A limitation on the number of school based scrimmages and regular season, school based contests in each sport or sport-activity, which shall not include post season contests and shall not exceed the allowable number of contests for that sport or sport-activity at the high school level; and

(e) A limitation on the length of the regular competitive season in each sport or sport-activity, not including any post season activities, which shall not exceed the length for that sport or sport-activity at the high school level;

(10)[(8)] Conduct all meetings related to middle school athletics in accordance with KRS 61.805 through 61.850;

(11)[(9)] Require that the common schools at the middle school level may only compete in contests against schools, including combined elementary or middle school teams, that adhere to these provisions; and

(12)[(10)] Issue an annual report to the Kentucky Board of Education on the status of interscholastic athletics at the middle school level, including any recommendations for changes in statute, administrative regulation, or policy; and

(13)[(11)] Nothing in this administrative regulation shall prohibit a school or school district from choosing to join a conference or association that has developed rules for any particular sport or sport-activity to satisfy the requirements of this administrative regulation.

Section 4. Financial Planning and Review Requirements. (1) KHSAA shall annually submit the following documents to the KBE by October 31:

(a) Draft budget for the next two (2) fiscal years, including the current year;

(b) End-of-year budget status report for the previous fiscal year;

(c) Revisions to the KHSAA Strategic Plan as a result of an annual review of the plan by the KHSAA governing body;

(d) A summary report of operations including summaries of financial, legal, and administrative actions taken and other items ongoing within KHSAA. This report shall also include a summary of items affecting:

1. Athletic appeals and their disposition including the name of the individual, grade, school, and the action taken by KHSAA;

2. Eligibility rules;

3. Duties of school officials;

4. Contests and contest limitations;

5. Requirements for officials and coaches; and

6. Results of a biennial review of its bylaws that results in a recommendation for a change, directing any proposals for change in association rules to be considered for vote by the member schools at the next legislative opportunity; and

(e) A review of all items which have been submitted to the membership for approval through the processes established in the KHSAA Constitution and the result of the voting on those issues.

(2) The KHSAA shall annually submit at the next meeting of the Kentucky Board of Education following receipt and adoption by the Board of Control, audited financial statements with the KHSAA Commissioner's letter addressing exceptions or notes contained in management correspondence, if any.

Section 5. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "KHSAA Constitution", 6/2013;

(b) "KHSAA Bylaws", 4/2014[9/2013];

(c) "KHSAA Due Process Procedure", 6/2013;

(d) "KHSAA Board of Control and Officials Division Policies", 4/2014[9/2013];

(e) "KHSAA Form BA101- Baseball Pitching Limitation", 4/2009;

(f) "KHSAA Form FB102- Football Financial Report", 9/7/2009;

(g) "KHSAA Form GE1- Membership Renewal", 4/2014[6/2013];

(h) "KHSAA Form GE2- New Membership Application", 4/2014[6/2013];

(i)["KHSAA Form GE3- Participation List", 4/2009;

(j)] "KHSAA Form GE4- Physician & Parental Permission Form", 4/2014[6/2013];

(j)[(k)] "KHSAA Form GE6- Domestic Transfer", 4/2014[9/2013];

(k)[(l)] "KHSAA Form GE7- Non Domestic Exchange Eligibility", 4/2014[9/2013];

(l)[(m)] "KHSAA Form GE8 - Non Domestic Non Exchange Eligibility", 4/2014[9/2013];

(m)[(n)] "KHSAA Form GE14- Contract for Athletic Contests", 4/2014[4/2009];

(n)[(o)] "KHSAA Form GE16- Statutory Waiver of Bylaw 3", 4/2014[3/2012];

(o)[(p)] "KHSAA Form GE19-Title IX Procedures Verification", 5/2011;

(p)[(q)] "KHSAA Form GE20- Heat Index Record", 4/2014[4/2009];

(q)[(r)] "KHSAA Form GE26- Financial Aid Report", 5/2011;

(r)[(s)] "KHSAA Form GE35- Waiver - 20 Day Notice", 4/2014[5/2011];

(s)[(t)] "KHSAA Form GE36- Add. Info for Appeal", 5/2011;

(t)[(u) "KHSAA Form GE40- Request for a Statutory Waiver of Bylaw 27", 2/2012;

(v)] "KHSAA Form GE52- District Tournament Financial Report", 4/2014[5/2011];

(u)[(w)] "KHSAA Form GE53- Region Tournament Financial Report", 4/2014 [3/2012];

(v)[(x)] "KHSAA Form GE69- Waiver – 15 Day Exceptions", 5/2011;

(w) "KHSAA Form SO112- Soccer Semi-State Financial Report", 4/2014;[(y) "KHSAA Form SO103- Soccer Section/SubSection Financial Report", 5/2011;

(z) "KHSAA Form WR101- Wrestling Permission Form", 12/2009;]

(x)[(aa)] "KHSAA Form WR111- Wrestling Skin Condition & Unconscious", 4/2014[5/2011];

(y)[(bb)] "KHSAA Form WR126- Wrestling Weight Certif. Program Assessor", 4/2014[3/2012]; and

(z)[(cc)] "KHSAA Form MS1 - Physician & Parental Permission", 9/2013.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Legal and Legislative Services, Department of Education, First Floor, Capital Plaza Tower, 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., Commissioner of Education
ROGER MARCUM, Chairperson

APPROVED BY AGENCY: April 15, 2014

FILED WITH LRC: April 15, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this proposed administrative regulation shall be held on May 22, 2014, at 10 a.m. in the State Board Room, First Floor, Capital Plaza Tower, 500 Mero Street, Frankfort, Kentucky. Individuals interested in being heard at this meeting 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 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 through close of business, June 2, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to:

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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Kevin Brown

(1) Provide a brief summary of:

(a) What this administrative regulation does: KRS 156.070 requires the Kentucky Board of Education (KBE) to manage and control the common schools, including interscholastic athletics in the schools, and authorizes the KBE to designate an agency to manage athletics. This regulation designates the Kentucky High School Athletic Association (KHSAA) as the agent to manage high school and middle school interscholastic athletics, and incorporates by reference the bylaws, procedures and rules governing interscholastic sports.

(b) The necessity of this administrative regulation: This regulation is necessary to designate the agency to provide the day-to-day management activities of interscholastic athletics in Kentucky; to set forth the financial, planning and review processes governing the agent; and to incorporate by reference the bylaws, procedures and rules of the agent.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation designates the agency to manage interscholastic athletics, as authorized by the authorizing statute, and outlines the conditions under which this authority is granted.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: It designates the KHSAA as the agent to manage interscholastic athletics in the schools and districts, and publishes changes in bylaws, procedures and rules for affected schools and districts.

(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: These amendments make changes to the documents incorporated by reference, in the KHSAA Bylaws, 6, 7, 8, 23, 25, and 27 as adopted by the KHSAA Delegate Assembly.

(b) The necessity of the amendment to this administrative regulation: Pursuant to the KHSAA Constitution, which is incorporated by reference in this regulation, the members are required to have an annual meeting to discuss and recommend any needed changes to the Constitution and Bylaws. While they are not required to make changes to the Constitution and Bylaws, changes must be made through this process. This amendment incorporates changes approved at the annual meeting of the Delegate Assembly. This amendment also is necessary to designate the KHSAA as the agent to manage interscholastic athletics at the middle school level.

(c) How the amendment conforms to the content of the authorizing statutes: The statute authorizes the KBE to designate an agency to manage interscholastic athletics in the common schools. The regulation designates the KHSAA as that agent, and incorporates by reference the KHSAA Handbook, which consists of the KHSAA Constitution, Bylaws, and Due Process to provide rules and guidance to the member schools and districts governing sporting events. The amendments in the Bylaws are made annually, according to the process outlined in the Constitution, and reflect input member schools and districts on changes that need to be made to provide a more sound structure of governance.

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

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: 174 School Districts

(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: There will be little impact because of the nature of the changes to the regulation. There are requirements that continue to be placed on schools and coaching personnel, however the training required to meet these requirements will be provided at no costs to the schools or the coaching personnel.

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

(a) Initially: Minimal

(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: KHSAA is funded through membership fees and dues, as well as from gate receipts from sporting events.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: None

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: None

(9) TIERING: Is tiering applied? Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all school districts.

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? School Districts.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 156.070 and 702 KAR 7:065.

(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 is no additional expense to the school districts 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? 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 costs associated to the KHSAA in administrating this program for the first year are minimal.

(d) How much will it cost to administer this program for subsequent years? The costs associated to the KHSAA in administrating this program in subsequent first years are minimal.

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 Department of Insurance
Financial Standards and Examination Division
(Amendment)

806 KAR 30:020. Abuse of minimum service charge.

RELATES TO: KRS 304.30-050, 304.30-090(3)
STATUTORY AUTHORITY: KRS 304.30-070
NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.30-070 authorizes[~~authorized~~] the commissioner[~~executive director~~] to make reasonable administrative regulations to effectuate the provisions of Subtitle 30 of the Kentucky Insurance Code and to regulate the manner in which licensed insurance premium finance companies conduct their business. This administrative regulation sets forth an untrustworthy act to be considered as sufficient to revoke or to suspend a license.

Section 1. Abuse of Minimum Service Charge Prohibited. No insurance agent or broker or premium finance agency shall induce an insured to become obligated under more than one (1) premium finance agreement for the purpose of obtaining more than one (1) minimum service charge[~~change~~] of fifteen (15)[~~ten (10)~~] dollars.

SHARON P. CLARK, Commissioner
ROBERT D. VANCE, Secretary
APPROVED BY AGENCY: April 10, 2014
FILED WITH LRC: April 15, 2014 at 10 a.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 22, 2014 at 9:00 a.m. (ET) at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by May 15, 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. 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 through the close of business on June 2, 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: DJ Wasson, Administrative Coordinator, Kentucky Department of Insurance, P. O. Box 517, Frankfort, Kentucky 4060, phone (502) 564-0888, fax (502) 564-1453.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: DJ Wasson
(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation prohibits an insurance agent or broker or premium finance agency from abusing the premium finance agreement.
(b) The necessity of this administrative regulation: It prohibits an insurance agent or broker or premium finance agency from inducing an insured to become obligated under more than one (1) premium finance agreement for the purpose of obtaining more than one (1) minimum service charge.
(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 304.30-070 authorized the commissioner to make reasonable administrative regulations to effectuate the provisions of Subtitle 30 of the Kentucky Insurance Code and to regulate the manner in which licensed insurance premium finance companies conduct their business. KRS 304.30-090(3) raises the additional service charge to fifteen (15) dollars per premium finance contract.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation prohibits an insurance agent or broker or premium finance agency from abusing the premium finance agreement.
(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 additional service charged per premium finance contract was raised from ten (10) to fifteen (15) dollars.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to provide the Department of Insurance with appropriate regulatory tools to take appropriate regulatory action against an agent or broker or premium finance agency who abuses the minimum service charge.
(c) How the amendment conforms to the content of the authorizing statutes: KRS 304.30-090(3) raises the additional service charge to fifteen (15) dollars per premium finance contract.
(d) How the amendment will assist in the effective administration of the statutes: This amendment makes clear the maximum amount allowed in the collection of this additional service charge.
(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Premium finance customers.
(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, 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 experience a small increase in a one-time, additional service charge.
(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Five (5) dollar increase per premium finance contract.
(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): This amendment will not affect the benefits.
(5) Provide an estimate of how much it will cost to implement this regulation:
(a) Initially: There will be no cost for implementation.
(b) On a continuing basis: None.
(6) What is the source of funding to be used for the implementation and enforcement of this administrative regulation: No funding is necessary.
(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, but the amendment pertains to a fee increase.
(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation raises fees.
(9) TIERING: Is tiering applied? Tiering is not applied as the provisions of this administrative regulation apply to all insurers 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 Insurance 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 304.30-070
(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.

(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.

(c) How much will it cost to administer this program for the first year? This regulation will be revenue neutral.

(d) How much will it cost to administer this program for subsequent years? This regulation will be revenue neutral.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

PUBLIC PROTECTION CABINET
Kentucky Department of Insurance
Financial Standards and Examination Division
(Amendment)

806 KAR 38:100. Risk-based capital for health organizations.

RELATES TO: KRS 304.32-140, 304.38-070, 304.38A-080, 304.38A-110

STATUTORY AUTHORITY: KRS 304.32-140(1), 304.38-070, 304.38-150, 304.38A-110(2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.32-140(1) requires a corporation subject to the requirements of KRS 304, Subtitle 32 to comply with the risk-based capital requirements as established in administrative regulations promulgated by the commissioner. KRS 304.38A-080 and 304.38A-110(2) require a limited health service organization and single service organization whose certificate of authority was converted to a limited health service organization to comply with the risk-based capital requirements for health organizations in administrative regulations promulgated by the commissioner. KRS 304.38-070 requires risk-based capital to be determined in accordance with the risk-based capital requirements established under KRS Chapter 304, Subtitle 38 and any administrative regulations promulgated pursuant to KRS Chapter 13A. KRS 304.38-150 provides that the Commissioner[~~Executive Director~~] of Insurance may make reasonable administrative regulations necessary for the proper administration of KRS Chapter 30 Subtitle 38. This administrative regulation requires[~~the~~] health maintenance organizations, limited health service corporations, and nonprofit health service corporations to comply with risk-based capital reporting requirements to aid in the department's[~~office's~~] financial monitoring[~~of health maintenance organizations~~].

Section 1. Definitions. As used in this administrative regulation, these terms shall have the following meanings:

(1) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner[~~executive director~~] in accordance with Section 2(5) of this administrative regulation.

(2) "Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(b) The notification by the commissioner[~~executive director~~] to the health organization of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, if the health organization does not challenge the adjusted RBC report under Section 7 of this administrative regulation;

(c) If, pursuant to Section 7 of this administrative regulation, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the commissioner[~~executive director~~] to the health organization that the commissioner[~~executive director~~] has, after a hearing, rejected the health organization's challenge;

(d) The failure of the health organization to respond, in a manner satisfactory to the commissioner[~~executive director~~], to a corrective order (provided the health organization has not challenged the corrective order under Section 7 of this administrative regulation); or

(e) If the health organization has challenged a corrective order under Section 7 of this administrative regulation and the commissioner[~~executive director~~] has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner[~~executive director~~], to the corrective order subsequent to rejection or modification by the commissioner[~~executive director~~].

(3) "Commissioner" is defined in KRS 304.1-050(1).

(4) "Company action level event" means any of the following events:

(a) The filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC;

(b) Notification by the commissioner[~~executive director~~] to the health organization of an adjusted RBC report that indicates an event in paragraph (a) of this subsection, if the health organization does not challenge the adjusted RBC report under Section 7 of this administrative regulation; or

(c) Pursuant to Section 7 of this administrative regulation, if a health organization challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the commissioner[~~executive director~~] to the health organization that the commissioner[~~executive director~~] has, after a hearing, rejected the health organization's challenge.

(5)[~~(4)~~] "Corrective order" means an order issued by the commissioner[~~executive director~~] specifying corrective actions which the commissioner[~~executive director~~] has determined are required.

(6) "Department" is defined in KRS 304.1-050(2).

(7)[~~(5)~~] "Domestic health organization" means a health organization domiciled in this state.

(8)[~~(6)~~] "Foreign health organization" means a health organization that is licensed to do business in this state under KRS Chapter 304 Subtitle 38, 38A or 32 but is not domiciled in this state.

(9)[~~(7)~~] "Health organization" means a health maintenance organization, limited health[~~single~~] service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under KRS Chapter 304 Subtitle 38, 38A, or 32. This definition does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer under KRS Chapter 304 Subtitle 24 or 3 and that is otherwise subject to either the life or property and casualty RBC requirements.

(10)[~~(8)~~] "Mandatory control level event" means any of the following events:

(a) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its Mandatory Control Level RBC;

(b) Notification by the commissioner[~~executive director~~] to the health organization of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, if the health organization does not challenge the adjusted RBC report under Section 7 of this administrative regulation; or

(c) Pursuant to Section 7 of this administrative regulation, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the commissioner[~~executive director~~] to the health organization

that the executive director has, after a hearing, rejected the health organization's challenge.

(11)[~~(9)~~] "NAIC" means the National Association of Insurance Commissioners.

(12) "RBC" means risk-based capital.

(13)[~~(10)~~] "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(14)[~~(11)~~] "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(a) "Company Action Level RBC" means, with respect to any health organization, the product of 2.0 and its Authorized Control Level RBC;

(b) "Regulatory Action Level RBC" means the product of one and five-tenths (1.5) and its Authorized Control Level RBC;

(c) "Authorized Control Level RBC" means the number[~~product of .50 and the risk-based capital after covariance (RBCAC)~~] determined under the risk-based capital formula in accordance with the RBC instructions;

(d) "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC.

(15)[~~(12)~~] "RBC plan" means a comprehensive financial plan containing the elements specified in Section 3(2) of this administrative regulation. [~~If the executive director rejects the RBC plan, and it is revised by the health organization, with or without the executive director's recommendation, the plan shall be called the "revised RBC plan."~~]

(16)[~~(13)~~] "RBC report" means the report required in Section 2 of this administrative regulation.

(17) "Regulatory action level event" means, with respect to a health organization, any of the following events:

(a) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

(b) Notification by the commissioner to a health organization of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the health organization does not challenge the adjusted RBC report under Section 7 of this administrative regulation;

(c) If, pursuant to Section 7 of this administrative regulation, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(d) The failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(e) The failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in Section 3(3) of this administrative regulation;

(f) Notification by the commissioner to the health organization that:

1. The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

2. Notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under Section 7 of this administrative regulation;

3. If, pursuant to Section 7 of this administrative regulation, the health organization challenges a determination by the commissioner under this paragraph, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge;

(g) Notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under Section 7 of this administrative regulation; or

(h) If, pursuant to Section 7 of this administrative regulation, the health organization challenges a determination by the commissioner under this paragraph, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

(18)[~~(14)~~] "Revised RBC plan" means an RBC plan that:

(a) Was rejected by the commissioner[~~executive director~~]; and

(b) Was revised by the health organization, with or without the commissioner's[~~executive director's~~] recommendation.

(19)[~~(15)~~] "Total adjusted capital" means the sum of:

(a) A health organization's statutory capital and surplus (i.e., net worth) as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under KRS 304.3-240 or 304.32-090; and

(b) Such other items, if any, as the RBC instructions may provide.

Section 2. RBC Reports. (1) A domestic health organization shall, on or prior to each March 1 (the "filing date"), prepare and submit to the commissioner[~~executive director~~] a report of its RBC levels as of the end of the calendar year just ended, in the 2013 NAIC Health Risk-Based Capital Report Including Overview and Instructions for Companies[~~"1999 NAIC Managed Care Organization Risk-Based Capital Report, including Overview and Instruction for Companies, 1999 HMO Annual Statement Version"~~]. In addition, a domestic health organization shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner[~~executive director~~] in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

1. Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

2. The filing date.

(2) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account [~~(~~]and may adjust for the covariance between[~~)~~] determined in each case by applying the factors in the manner set forth in the RBC instructions.

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business and relevant risks as are set forth in the RBC instructions.[~~(e) An excess of capital (i.e., net worth) over the amount produced by the risk-based capital requirements contained in the administrative regulation and the formulas, schedules and instructions referenced in this administrative regulation is desirable in the business of health insurance. Accordingly, health organizations shall seek to maintain capital above the RBC levels required by this administrative regulation. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this administrative regulation.~~]

(3) If a domestic health organization files an RBC report that in the judgment of the commissioner[~~executive director~~] is inaccurate, then the commissioner[~~executive director~~] shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report".[~~(4) A domestic health organization shall file an additional interim RBC report if the executive director deems an interim report necessary to accurately perform ongoing financial examination or financial analysis of the health organization.~~]

~~(5) A domestic health organization may file an additional interim RBC report if:~~

~~(a) The domestic health organization has experienced a material change in its operations or finances so that the most recently filed RBC report materially misstates the true conditions of the domestic health organization; and~~

~~(b) The domestic health organization receives prior written approval of the executive director for the interim RBC report filing.~~

~~(6) An interim RBC report shall be prepared in compliance with subsection (1) of this section. The executive director shall designate the time period which the interim RBC shall cover.~~]

Section 3. Company Action Level Event. (1) In the event of a company action level event, the health organization shall prepare and submit to the commissioner[~~executive director~~] an RBC plan that shall:

(a) Identify the conditions that contribute to the company action level event;

(b) Contain proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the company action level event;

(c) Provide projections of the health organization's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(2) The RBC plan shall be submitted

(a) Within forty-five (45) days of the company action level event; or

(b) If the health organization challenges an adjusted RBC report pursuant to Section 7 of this administrative regulation, within forty-five (45) days after notification to the health organization that the commissioner[~~executive director~~] has, after a hearing, rejected the health organization's challenge.

(3) Within sixty (60) days after the submission by a health organization of an RBC plan to the commissioner[~~executive director~~], the commissioner[~~executive director~~] shall notify the health organization whether the RBC plan shall be implemented or is[~~, in the judgment of the executive director,~~] unsatisfactory. If the commissioner[~~executive director~~] determines the RBC plan is unsatisfactory, the notification to the health organization shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner[~~executive director~~]. Upon notification from the commissioner[~~executive director~~], the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner[~~executive director~~], and shall submit the revised RBC plan to the commissioner[~~executive director~~]:

(a) Within forty-five (45) days after the notification from the commissioner[~~executive director~~]; or

(b) If the health organization challenges the notification from the commissioner[~~executive director~~] under Section 7 of this administrative regulation, within forty-five (45) days after a notification to the health organization that the commissioner[~~executive director~~] has, after a hearing, rejected the health organization's challenge.

(4) In the event of a notification by the commissioner[~~executive director~~] to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner[~~executive director~~] may[~~at the executive director's discretion~~], subject to the health organization's right to a hearing under Section 7 of this administrative regulation, specify in the notification that the notification constitutes a regulatory action level event.

(5) Every domestic health organization that files an RBC plan or revised RBC plan with the commissioner[~~executive director~~] shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner[~~executive director~~] in any state in which the health organization is authorized to do business if:

(a) The state has an RBC provision substantially similar to Section 8(1) of this administrative regulation; and

(b) The insurance commissioner[~~executive director~~] of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

1. Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

2. The date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4) of this section.

Section 4. Regulatory Action Level Event. (1)[~~"Regulatory action level event" means, with respect to a health organization, any of the following events:~~

~~(a) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;~~

~~(b) Notification by the executive director to a health organization of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the health organization does not challenge the adjusted RBC report under Section 7 of this administrative regulation;~~

~~(c) If, pursuant to Section 7 of this administrative regulation, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the executive director to the health organization that the executive director has, after a hearing, rejected the health organization's challenge;~~

~~(d) The failure of the health organization to file an RBC report by the filing date, unless the health organization has provided an explanation for the failure that is satisfactory to the executive director and has cured the failure within ten (10) days after the filing date;~~

~~(e) The failure of the health organization to submit an RBC plan to the executive director within the time period set forth in Section 3(3) of this administrative regulation;~~

~~(f) Notification by the executive director to the health organization that:~~

~~1. The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and~~

~~2. Notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under Section 7 of this administrative regulation;~~

~~3. If, pursuant to Section 7 of this administrative regulation, the health organization challenges a determination by the executive director under paragraph (f) of this subsection, the notification by the executive director to the health organization that the executive director has, after a hearing, rejected the challenge;~~

~~(g) Notification by the executive director to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the executive director has so stated in the notification, provided the health organization has not challenged the determination under Section 7 of this administrative regulation; or~~

~~(h) If, pursuant to Section 7 of this administrative regulation, the health organization challenges a determination by the executive director under paragraph (h) of this subsection, the~~

notification by the executive director to the health organization that the executive director has, after a hearing, rejected the challenge.

(2)] In the event of a regulatory action level event the commissioner[executive director] shall:

(a) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform an[such] examination or analysis[as the executive director deems necessary] of the assets, liabilities and operations of the health organization including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying corrective actions as the commissioner[executive director] shall determine are required [(a "corrective order")].

(2)[(3)]In determining corrective actions, the commissioner[executive director] may take into account factors the[executive director deems] relevant with respect to the health organization based upon the commissioner's[executive director's] examination or analysis of the assets, liabilities and operations of the health organization, including the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five (45) days after the occurrence of the regulatory action level event;

(b) If the health organization challenges an adjusted RBC report pursuant to Section 7 of this administrative regulation and the challenge is not frivolous in the judgment of the executive director within forty-five (45) days after the notification to the health organization that the commissioner[executive director] has, after a hearing, rejected the health organization's challenge; or

(c) If the health organization challenges a revised RBC plan pursuant to Section 7 of this administrative regulation and the challenge is not frivolous in the judgment of the executive director, within forty-five (45) days after the notification to the health organization that the commissioner[executive director] has, after a hearing, rejected the health organization's challenge.

(3)[(4)] The commissioner[executive director] may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner[executive director] to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations [{]including contractual relationships[}] of the health organization and formulate the corrective order with respect to the health organization. The fees, costs and expenses relating to consultants shall be borne by the affected health organization or such other party as directed by the commissioner[executive director].

Section 5. Authorized Control Level Event.[(1) "Authorized control level event" means any of the following events:

(a) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

(b) The notification by the executive director to the health organization of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, if the health organization does not challenge the adjusted RBC report under Section 7 of this administrative regulation;

(c) If, pursuant to Section 7 of this administrative regulation, the health organization challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the executive director to the health organization that the executive director has, after a hearing, rejected the health organization's challenge;

(d) The failure of the health organization to respond, in a manner satisfactory to the executive director, to a corrective order (provided the health organization has not challenged the corrective order under Section 7 of this administrative regulation); or

(e) If the health organization has challenged a corrective order under Section 7 of this administrative regulation and the executive director has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the executive director, to the corrective order subsequent to rejection or modification by the executive director.

(2)] In the event of an authorized control level event with respect to a health organization, the commissioner[executive director] shall:

(1)[(a)] Take action as required under Section 4 of this administrative regulation regarding a health organization with respect to which an regulatory action level event has occurred; or

(2)[(b)] If the commissioner determines[executive director deems] it to be in the best interests of the policyholders and creditors of the health organization and of the public, take action as necessary to cause the health organization to be placed under regulatory control under KRS Chapter 304 Subtitle 33. In the event the commissioner[executive director] takes action, the authorized control level event shall be[deemed] sufficient grounds for the commissioner[executive director] to take action under KRS Chapter 304 Subtitle 33, and the commissioner[executive director] shall have the rights, powers and duties with respect to the health organization as are set forth in KRS Chapter 304 Subtitle 33. If[In the event] the commissioner[executive director] takes actions under this paragraph pursuant to an adjusted RBC report, the health organization shall be entitled to protections as are afforded to health organizations under the provisions of Section KRS 304.33-130 pertaining to summary proceedings.

Section 6. Mandatory Control Level Event. (1) In the event of a mandatory control level event, the commissioner[executive director] shall take action as necessary to place the health organization under regulatory control under KRS Chapter 304 Subtitle 33. In that event, the mandatory control level event shall be[deemed] sufficient grounds for the commissioner[executive director] to take action under KRS Chapter 304 Subtitle 33, and the commissioner[executive director] shall have the rights, powers and duties with respect to the health organization as are set forth in KRS Chapter 304 Subtitle 33.

(2) If the commissioner[executive director] takes actions pursuant to an adjusted RBC report, the health organization shall be entitled to the protections of Section KRS 304.33-130 pertaining to summary proceedings.

(3) The commissioner[Notwithstanding any of the foregoing, the executive director] may forego action for up to ninety (90) days after the mandatory control level event if the commissioner[executive director] finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

Section 7. Hearings. Upon the occurrence of any of the following events the health organization shall have the right to a confidential departmental[office] hearing, on a record, at which the health organization may challenge any determination or action by the commissioner[executive director]. The health organization shall notify the commissioner[executive director] of its request for a hearing within five (5) days after the notification by the commissioner[executive director] of any of the following events:

(1) Notification to a health organization by the commissioner[executive director] of an adjusted RBC report;

(2) Notification to a health organization by the commissioner[executive director] that:

(a) The health organization's RBC plan or revised RBC plan is unsatisfactory; and

(b) Notification constitutes a regulatory action level event with respect to the health organization;

(3) Notification to a health organization by the commissioner[executive director] that the health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

(4) Notification to a health organization by the commissioner[executive director] of a corrective order with respect to the health organization.

Section 8. Confidentiality; Prohibition on Announcements,

Prohibition on Use in Ratemaking. (1) All RBC reports [{]to the extent the information is not required to be set forth in a publicly available annual statement schedule[}] and RBC plans [{]including the results or report of any examination or analysis of a health organization performed pursuant to this statute and any corrective order issued by the commissioner[executive director] pursuant to examination or analysis[}] with respect to a domestic health organization or foreign health organization that are in the possession or control of the Department of Insurance shall be confidential by law and privileged, shall not be subject to KRS 61.870 et seq, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private action. The commissioner may use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties[filed with the executive director constitute information that may be damaging to the health organization if made available to its competitors, and therefore shall be kept confidential by the executive director. This information shall not be made public, except by the executive director and then only for the purpose of enforcement actions taken by the executive director pursuant to this administrative regulation or any other provision of the insurance laws of this state].

(2) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subjection to subsection (1) of this section.

(3) In order to assist the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subjection to subsection (1) of this section with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(b) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) May enter into agreements governing sharing and use of information consistent with this section.

(4) Except as otherwise required under the provisions of this administrative regulation, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation, by any health organization, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; however, if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its RBC levels [{]or any of them[}] or an inappropriate comparison of any other amount to the health organizations' RBC levels is published in any written publication and the health organization is able to demonstrate to the executive director with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(5)[(3)] The RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner[executive director] in monitoring the solvency of health organizations and the need for possible corrective action with respect to health organizations and shall not be used by the commissioner[executive director] for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner[executive director] to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

Section 9. Supplemental Provisions; Rules; Exemption. (1) The provisions of this administrative regulation are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the commissioner under the law, including KRS Chapter 304 Subtitles 32, 33, 37 or 38, 304.2-065 or 806 KAR 3:150.

(2) The commissioner[executive director] may exempt from the application of this administrative regulation a domestic health organization that:

(a) Writes direct business only in this state;

(b) Assumes no reinsurance in excess of five (5) percent of direct premium written; and

(c) Writes direct annual premiums for comprehensive medical business of $2,000,000 or less or is a limited health[single] service organization that covers less than 2,000[2000] lives.

Section 10. Foreign Health Organizations. (1)(a) A foreign health organization shall, upon the written request of the commissioner[executive director], submit to the commissioner[executive director] an RBC report as of the end of the calendar year just ended the later of:

1. The date an RBC report would be required to be filed by a domestic health organization under this administrative regulation; or

2. Fifteen (15) days after the request is received by the foreign health organization.

(b) A foreign health organization shall, at the written request of the commissioner[executive director], promptly submit to the commissioner[executive director] a copy of any RBC plan that is filed with the insurance commissioner[executive director] of any other state.

(2) In the event of a company action level event, regulatory action level event or authorized control level event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization [{]or, if no RBC statute is in force in that state, under the provisions of this administrative regulation[}], if the insurance commissioner[executive director] of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute [{]or, if no RBC statute is in force in that state, under Section 3 of this administrative regulation[}], the commissioner[executive director] may require the foreign health organization to file an RBC plan with the commissioner[executive director]. In that event, the failure of the foreign health organization to file an RBC plan with the commissioner[executive director] shall be grounds to order the health organization to cease and desist from writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to a foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the commissioner[executive director] may make application to the Franklin Circuit Court permitted under the KRS Chapter 304 Subtitle 33 with respect to the liquidation of property of foreign health organizations found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

Section 11.[Phase-In Provision. (1) For RBC reports required to be filed by health organizations with respect to 2000, the

~~following requirements shall apply in lieu of the provisions of Sections 3, 4, 5 and 6 of this administrative regulation:~~

~~(a) In the event of a company action level event with respect to a domestic health organization, the executive director shall take no regulatory action under this administrative regulation.~~

~~(b) In the event of an regulatory action level event under Section 4(1)(a), (b) or (c) of this administrative regulation, the executive director shall take the actions required under Section 3 of this administrative regulation.~~

~~(c) In the event of an regulatory action level event under Section 4(1)(d), (e), (f), (g), (h) or (i) of this administrative regulation or an authorized control level event, the executive director shall take the actions required under Section 4 of this administrative regulation with respect to the health organization.~~

~~(d) In the event of a Mandatory Control Level Event with respect to a health organization, the executive director shall take the actions required under Section 5 of this administrative regulation with respect to the health organization.~~

~~(2) Notwithstanding Section 1(8)(d) of this administrative regulation, for RBC reports required to be filed by health organizations with respect to 2000, "Authorized Control Level RBC" shall equal forty (40) percent of the Risk Based Capital After Covariance (RBCAC) determined under the risk-based capital formula in accordance with the RBC instructions; and for the RBC reports required to be filed by health organizations with respect to 2001, "Authorized Control Level RBC" shall equal forty-five (45) percent of the Risk Based Capital After Covariance (RBCAC) determined under the risk-based capital formula in accordance with the RBC instructions. Thereafter, the definition in Section 1(8)(d) of this administrative regulation shall apply.~~

~~Section 12.~~] Incorporation by Reference. (1) "2013 NAIC Health Risk-Based Capital Report Including Overview and Instructions for Companies"[~~"1999 NAIC Managed Care Organization Risk-Based Capital Report, including Overview and Instructions for Companies, 1999 HMO Annual Statement Version", (11/1/99 Edition)~~], National Association of Insurance Commissioners, is incorporated by reference.

(2) This material[~~It~~] may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department[~~Office~~] of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

SHARON P. CLARK, Commissioner
ROBERT D. VANCE, Secretary
APPROVED BY AGENCY: April 10, 2014
FILED WITH LRC: April 15, 2014 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 22, 2014 at 9:00 a.m. (ET) at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by May 15, 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. 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 through the close of business on June 2, 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: DJ Wasson, Administrative Coordinator, Kentucky Department of Insurance, P. O. Box 517, Frankfort, Kentucky 40602, phone (502) 564-0888, fax (502) 564-1453.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: DJ Wasson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes risk-based capital requirements for all health maintenance organizations authorized to transact insurance business in Kentucky. This regulation also sets forth the required actions to be taken by both the commissioner and the insurer if the health maintenance organization fails to meet the risk-based capital requirements.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to provide the department with the appropriate monitoring and enforcement tools to ensure the financial solvency of health maintenance organizations doing business in Kentucky.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 304.38-070 requires risk-based capital to be determined in accordance with the risk-based capital requirements established under KRS 304, Subtitle 38 and any administrative regulations promulgated pursuant to KRS 13A. KRS 304.38-150 provides that the Commissioner of Insurance may make reasonable administrative regulations necessary for the proper administration of KRS Chapter 304, Subtitle 38. This administrative regulation requires health maintenance organizations to comply with risk-based capital reporting requirements to aid in the department's financial monitoring of health maintenance organizations.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation sets forth the process that the department will use in monitoring solvency and the required corrective action for a health maintenance organization that does not meet the risk-based capital 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 will add limited service health maintenance organizations and non-profit health service corporations as entities required to follow the provisions in this administrative regulation, as required by statute. Additionally, the risk-based capital requirements are being updated to the new requirements adopted by all accredited states.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to provide the Department of Insurance with appropriate regulatory tools to take appropriate regulatory action against a health maintenance organization, limited service health maintenance organization and non-profit health service corporation that is exhibiting a negative trend in its financial status.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 304.32-140(1) requires a corporation subject to the requirements of KRS 304, Subtitle 32 to comply with the risk-based capital requirements as established in administrative regulations promulgated by the commissioner. KRS 304.38A-080 and 304.38A-110(2) require a limited health service organization and single service organization whose certificate of authority was converted to a limited health service organization to comply with the risk-based capital requirements for health organizations in administrative regulations promulgated by the commissioner. KRS 304.38-070 requires risk-based capital to be determined in accordance with the risk-based capital requirements established under KRS Chapter 304, Subtitle 38 and any administrative regulations promulgated pursuant to KRS 13A. KRS 304.38-150 provides that the Commissioner of Insurance may make reasonable administrative regulations necessary for the proper administration of KRS Chapter 30 Subtitle 38. This administrative regulation requires the health maintenance organizations, limited health service corporations, and nonprofit health service corporations to comply with risk-based capital reporting requirements to aid in the department's financial monitoring

(d) How the amendment will assist in the effective administration of the statutes: This amendment sets forth the process that the department will use in monitoring solvency of a health maintenance organizations, limited service health benefit plans and non-profit health service corporation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this

administrative regulation: Approximately thirty (30) regulated entities will be impacted by this administrative regulation.

(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, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Regulated entities are responsible for maintaining capital and surplus in accordance with the requirements set forth in this administrative regulation. Should a regulated entity fail to maintain the capital and surplus required by this administrative regulation, the entity is responsible for following the corrective action set forth 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): Regulated entities have been complying with these requirements for numerous years. There should not be a cost for complying with the updates included in this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): As a result of compliance, regulated entities will be able to fulfill their financial obligations to their insureds.

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

(a) Initially: There will not be an additional cost to implement this administrative regulation initially. The Department has existing staff to perform this function.

(b) On a continuing basis: There will not be a cost to implement this administrative regulation on a continuing basis.

(6) What is the source of funding to be used for the implementation and enforcement of this administrative regulation: The budget of the Department of Insurance.

(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:

An increase in fees will not 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 directly or indirectly increase fees.

(9) TIERING: Is tiering applied? Tiering is not applied as the provisions of this administrative regulation apply to all entities 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 Insurance 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 304.32-140(1), 304.38-070, 304.38-150, 304.38A-110(2)

(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 in the first year.

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

(c) How much will it cost to administer this program for the first year? This regulation will be revenue neutral. There will not be an additional cost to administer this program in the first year. Existing staff at the Department of Insurance currently perform this function.

(d) How much will it cost to administer this program for subsequent years? There will not be an additional 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 amendment to this existing administrative regulation offers technical clarifications and will not have a revenue impact.

PUBLIC PROTECTION CABINET
Kentucky Department of Insurance
Division of Insurance Fraud Investigation
(Amendment)

806 KAR 47:010. Designation of a contact person.

RELATES TO: KRS 304.47-040, 304.47-050, 304.47-080

STATUTORY AUTHORITY: KRS 304.2-110, 304.47-040, 304.47-080

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110 provides that the Commissioner[~~Executive Director~~] of Insurance may make reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. This administrative regulation requires insurers to designate a contact person to communicate with the Division of Insurance Fraud Investigation[~~Insurance Fraud Unit~~]. This administrative regulation will assist insurers with their reporting requirement of KRS 304.47-050.

Section 1. Every insurer shall designate at least two (2)[~~one (1)~~] primary contact persons[~~person~~] but not more than four (4) primary contact persons who shall communicate with the Division of Insurance Fraud Investigation[~~Insurance Fraud Unit~~] on matters relating to the reporting, investigation, and prosecution of suspected fraudulent insurance acts as defined in KRS 304.47-020.

Section 2. Every insurer shall notify the Division of Insurance Fraud Investigation[~~Insurance Fraud Unit~~] in writing of the names, addresses, and telephone numbers of:

(1) The insurer's primary contact[~~person or~~] persons; and

(2) The primary person responsible for the insurer's investigative unit.

SHARON P. CLARK, Commissioner
ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: April 10, 2014

FILED WITH LRC: April 15, 2014 at 10 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 22, 2014 at 9:00 a.m. (ET) at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by May 15, 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 through the close of business on June 2, 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: DJ Wasson, Administrative Coordinator, Kentucky Department of Insurance, P. O. Box 517, Frankfort,

Kentucky 40602, phone (502) 564-0888, fax (502) 564-1453.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: DJ Wasson

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation amends the name of the Insurance Fraud Unit to the Division of Insurance Fraud Investigation and requires all insurance companies authorized to do business in Kentucky to designate at least one contact person to communicate with the Department regarding suspected insurance fraud.

(b) The necessity of this administrative regulation: This administrative regulation updates the name of the division to make it consistent with related statutes. It also requires companies to provide a contact name/address/phone number to further efforts to investigate allegations of insurance fraud.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 304.2-110 provides that the Commissioner of Insurance may make reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code. KRS 304.47-040 creates a Division of Insurance Fraud Investigation within the Department of Insurance and sets up the authority of special investigators within that division. KRS 304.47-080 requires all insurance companies operating in Kentucky to maintain a method to identify, investigate, and report instances of insurance fraud.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation sets forth the process that the Department of Insurance and insurance company special investigation units use to identify, investigate, deter and report instances of suspected 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 a change in the name of the entity within the Department that is responsible for investigating insurance fraud allegations. Previously the Fraud Investigation Unit, the entity is now the Division of Insurance Fraud Investigation.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to provide the correct name of the division within the Department of Insurance.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 304.2-110 provides that the Commissioner of Insurance may make reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code, KRS 304.1-010. KRS 304.47-040 creates the Division of Insurance Fraud Investigation within the Department of Insurance.

(d) How the amendment will assist in the effective administration of the statutes: This amendment provides uniformity in naming the relevant division and should reduce possible confusion.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: There will be no impact.

(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, 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 be required.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): There is no cost for complying with the updates included in this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): There are no additional benefits associated with the amendment.

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

(a) Initially: There will not be an additional cost to implement this administrative regulation.

(b) On a continuing basis: There will not be a cost to implement this administrative regulation on a continuing basis.

(6) What is the source of funding to be used for the implementation and enforcement of this administrative regulation: The budget of the Department of Insurance.

(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: An increase in fees will not 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 directly or indirectly increase fees.

(9) TIERING: Is tiering applied? Tiering is not applied as the provisions of this administrative regulation apply to all insurers 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 Department of Insurance 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 304.2-110, 304.47-040, 304.47-080

(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? This administrative regulation will not generate revenue for the Department of Insurance.

(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.

(c) How much will it cost to administer this program for the first year? This regulation will be revenue neutral.

(d) How much will it cost to administer this program for subsequent years? There will not be an additional 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 amendment to this existing administrative regulation offers technical clarifications and will not have a revenue impact.

PUBLIC PROTECTION CABINET
Department of Housing, Buildings and Construction
Division of Building Code Enforcement
(Amendment)

815 KAR 7:120. Kentucky Building Code.

RELATES TO: KRS 132.010(9), (10), 198B.010, 198B.040, 198B.050, 198B.060, 198B.080, 198B.110, 198B.260, 198B.990, 227.300, 227.550(7)

STATUTORY AUTHORITY: KRS 198B.040(7), 198B.050

NECESSITY, FUNCTION, AND CONFORMITY: KRS 198B.040(7) and 198B.050 require the Kentucky Board of Housing,

Buildings, and Construction to adopt and promulgate a mandatory uniform statewide building code, based on a model code, which establishes standards for construction of buildings in the state. This administrative regulation establishes the Kentucky Building Code's general provisions.

Section 1. Definitions. (1) "Board of Housing" or "board" means the Kentucky Board of Housing, Buildings, and Construction.

(2) "Building" is defined by KRS 198B.010(4).

(3) "Commissioner" is defined by KRS 198B.010(9).

(4) "Department" is defined by KRS 198B.010(11).

(5) "Farm" means property:

(a) Located outside the corporate limits of a municipality on at least ten (10) acres;

(b) Used for purposes established in the definitions of "agricultural land" and "horticultural land", established in KRS 132.010(9) and (10), respectively; and

(c) Qualified by and registered with the property valuation administrator in that county.

(6) "Fire Code Official" means the State Fire Marshal, fire chief, or other enforcement officer designated by the appointing authority of the jurisdiction for the enforcement of the provisions of KRS 227.300 and the Kentucky Standards of Safety as established in 815 KAR 10:060.

(7) "Industrialized building system" or "building system" is defined by KRS 198B.010(16).

(8) "KBC" means the Kentucky Building Code as established in this administrative regulation.

(9) "Kentucky Residential Code" means the International Residential Code as incorporated by reference and amended for application in Kentucky by 815 KAR 7:125.

(10) "Kentucky Standards of Safety" means the requirements established in 815 KAR 10:060, which serve as the fire prevention code for existing buildings as well as a supplement to this code.

(11) "Manufactured home" is defined by KRS 227.550(7).

(12) "Modular home" means an industrialized building system, which is designed to be used as a residence and that is not a manufactured or mobile home.

(13) "Ordinary repair" is defined by KRS 198B.010(19).

(14) "Single-family dwelling" or "one (1) family dwelling" means a single unit that:

(a) Provides complete independent living facilities for one (1) or more persons including permanent provisions for living, sleeping, eating, cooking, and sanitation; and

(b) Is not connected to another unit or building.

(15) "Townhouse" means a single-family dwelling unit constructed in a group of three (3) or more attached units separated by property lines in which each unit extends from foundation to roof and with open space on at least two (2) sides.

(16) "Two (2) family dwelling" means a building containing not more than two (2) dwelling units that are connected.

Section 2. Administration and Enforcement of the Building Code. (1) Notwithstanding the requirements of the 2012 International Building Code, the Kentucky amendments established in the 2013 Kentucky Building Code shall be mandatory and shall supersede any conflicting provision of the international code.

(2)(a) Except as provided in paragraph (b) and (c) of this subsection and as superseded by the provisions of this administrative regulation and the 2013 Kentucky Building Code, the 2012 International Building Code, shall be the mandatory state building code for all buildings constructed in Kentucky.

(b) One (1) and two (2) family dwellings and townhouses shall be governed by 815 KAR 7:125.

(c) Manufactured homes shall be governed by KRS 227.550 through 227.665.

Section 3. State Plan Review and Inspection Fees. The fees required by this section shall apply for plan review and inspection by the department. (1) Fast track elective.

(a) A request for expedited site and foundation approval of one (1) week or less, prior to full review of the complete set of construction documents, shall be accompanied by the fee required by Table 121.3.1 in subsection (3) of this section, plus an additional fifty (50) percent of the basic plan review or inspection fee.

(b) The additional fifty (50) percent fee shall not be less than $400 and not more than $3,000.

(c) The entire fee shall be paid with the initial plan submission.

(2) New buildings.

(a) The department's inspection fees shall be calculated by:

1. Multiplying the total building area under construction by the cost per square foot of each occupancy type as listed in subsection (3) of this section; and

2. Computing the square footage by the outside dimensions of the building.

(b) The fee for a building[~~buildings~~] with multiple or mixed occupancies shall be calculated using the cost per square foot multiplier of the predominant use.

(3) Table 121.3.1, Basic Department Fee Schedule. The basic plan review or inspection fee shall be:

(a) Assembly occupancies, fourteen (14) cents;

(b) Business occupancies, thirteen (13) cents;

(c) Day care centers, thirteen (13) cents;

(d) Educational occupancies, thirteen (13) cents;

(e) High hazard occupancies, twelve (12) cents;

(f) Industrial factories, twelve (12) cents;

(g) Institutional occupancies, fourteen (14) cents;

(h) Mercantile occupancies, thirteen (13) cents;

(i) Residential occupancies, thirteen (13) cents;

(j) Storage, eleven (11) cents; or

(k) Utility and miscellaneous, eleven (11) cents.

(4) Additions to existing buildings.

(a) Plan review fees for additions to existing buildings, which shall not require the entire building to conform to the Kentucky Building Code, shall be calculated in accordance with the schedule listed in subsection (3) of this section by the measurement of the square footage of the addition, as determined by the outside dimensions of the addition.

(b) The minimum fee for review of plans pursuant to this subsection shall be $250.

(5) Change in use.

(a) Plan review fees for existing buildings in which the use group or occupancy type is changed shall be calculated in accordance with the schedule listed in subsection (3) of this section by using the total square footage of the entire building or structure pursuant to the new occupancy type as determined by the outside dimensions.

(b) The minimum fee for review of plans pursuant to this subsection shall be $250.

(6) Alterations and repairs.

(a) Plan review fees for alterations and repairs not otherwise covered by this fee schedule shall be calculated by using the lower result of:

1. Multiplying the cost for the alterations or repairs by 0.0025; or

2. Multiplying the total area being altered or repaired by the cost per square foot of each occupancy type listed in the schedule in subsection (3) of this section.

(b) The total square footage shall be determined by the outside dimensions of the area being altered or repaired.

(c) The minimum fee for review of plans pursuant to this subsection shall be $275.

(7) Specialized fees. In addition to the fees established by subsections (1) through (6) of this section, the following fees shall be applied for the specialized plan reviews listed in this subsection:

(a) Table 121.3.9, Automatic Sprinkler Review Fee Schedule:

1. An inspection of four (4) through twenty-five (25) sprinklers shall be a fee of $150;

2. An inspection of twenty-six (26) through 100 sprinklers shall be a fee of $200;

3. An inspection of 101 through 200 sprinklers shall be a fee of $250;

4. An inspection of 201 through 300 sprinklers shall be a fee of $275;

5. An inspection of 301 through 400 sprinklers shall be a fee of

$325;

6. An inspection of 401 through 750 sprinklers shall be a fee of $375; and

7. An inspection of over 750 sprinklers shall be a fee of $375 plus thirty (30) cents per sprinkler over 750.

(b) Fire detection system review fee:

1. Zero through 20,000 square feet shall be $275; and

2. Over 20,000 square feet shall be $275 plus thirty (30) dollars for each additional 10,000 square feet in excess of 20,000 square feet.

(c) The standpipe plan review fee shall be $275. The combination stand pipe and riser plans shall be reviewed pursuant to the automatic sprinkler review fee schedule.

(d) Carbon dioxide suppression system review fee:

1. One (1) through 200 pounds of agent shall be $275; and

2. Over 200 pounds of agent shall be $275 plus five (5) cents per pound in excess of 200 pounds.

(e) Clean agent suppression system review fee:

1.a. Up to thirty-five (35) pounds of agent shall be $275; and

b. Over thirty-five (35) pounds shall be $275 plus ten (10) cents per pound in excess of thirty-five (35) pounds; and

2. The fee for gaseous systems shall be ten (10) cents per cubic foot and not less than $150.

(f) Foam suppression system review fee.

1. The fee for review of a foam suppression system shall be fifty (50) cents per gallon of foam concentrate if the system is not part of an automatic sprinkler system.

2. Foam suppression system plans that are submitted as part of an automatic sprinkler system shall be reviewed pursuant to the automatic sprinkler review fee schedule.

3. The fee for review of plans pursuant to subparagraph 1. of this paragraph shall not be less than $275 or more than $1,500.

(g) The commercial range hood review fee shall be $225 per hood.

(h) Dry chemical systems review fee (except range hoods). The fee for review of:

1. One (1) through thirty (30) pounds of agent shall be $275; and

2. Over thirty (30) pounds of agent shall be $275 plus twenty-five (25) cents per pound in excess of thirty (30) pounds.

(i) The flammable, combustible liquids or gases, and hazardous materials plan review fee shall be $100 for the first tank, plus fifty (50) dollars for each additional tank and $100 per piping system including valves, fill pipes, vents, leak detection, spill and overfill detection, cathodic protection, or associated components.

(j) Boiler and unfired pressure vessel fees. Plan review fees of boiler and unfired pressure vessel installations shall be in accordance with 815 KAR 15:027.

Section 4. General. All plans shall be designed and submitted to conform to this administrative regulation.

Section 5. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "2012 International Building Code", First Edition, International Code Council, Inc.; and

(b) "2013 Kentucky Building Code", Second[~~Tenth~~] Edition, February 2014[~~2013, June 2013~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Housing, Buildings and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky 40601-5412[~~5405~~], Monday through Friday, 8 a.m. to 4:30 p.m.

AMBROSE WILSON IV, Chairman
JACK COLEMAN, Deputy Commissioner
ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: April 7, 2014

FILED WITH LRC: April 8, 2014 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Thursday, May 22, 2014, at 10:00 a.m., EDT, in the Department of Housing, Buildings and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by Thursday, May 15, 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 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 close of business on June 2, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation by the above date to the contact person:

CONTACT PERSON: Michael T. Davis, General Counsel, Department of Housing, Buildings and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky 40601-5412, phone 502-573-0365 ext. 144, fax 502-573-1057.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Michael T. Davis

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the uniform Kentucky Building Code as required pursuant to KRS 198B.050.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order to adopt the Kentucky Building Code as required pursuant to KRS 198B.050.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation utilizes the International Building Code as the basis for construction standards and allows the Board of Housing, Buildings and Construction to make amendments unique to Kentucky after due consideration of equivalent safety measures as required by KRS 198B.050.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation sets forth standards authorized by the statute for the enforcement of the uniform state building code, incorporating all applicable laws into its processes.

(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: Updates the 2013 Kentucky Building Code to correct inadvertent typographical, citation and formatting errors that were not identified late last year when this administrative regulation was amended to establish the 2013 Kentucky Building Code. In addition, this amendment corrects inadvertent omissions from the 2013 KBC to restore language that was adopted by the Board of Housing, Buildings and Construction but omitted as a result of drafting errors. These sections include Section 2 (Definitions), Section 1507 (Requirements for Roof Coverings), Section 1602 (Definitions and Notations), Section 2113 (Masonry Chimneys), and Chapter 29 (Plumbing Systems). Finally, this amendment further updates the 2013 KBC to reflect adoption of the 2012 International Energy Conservation Code and the 2014 National Electrical Code.

(b) The necessity of the amendment to this administrative regulation: To implement code changes originally approved by the Board of Housing, Buildings and Construction during its May 2013 adoption, and reaffirmed during its December 2013 meeting, as well as the updated referenced standards adopted during its February 2014 meeting.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 198B mandates the Board of Housing, Buildings and Construction to establish a uniform Kentucky Building Code. These amendments were approved by the Board to update, correct and amend the current 2013 Kentucky Building Code.

(d) How the amendment will assist in the effective administration of the statutes: These amendments to the Kentucky Building Code are intended to enhance public safety and to allow

the construction industry to utilize an updated version of the model code and its referenced codes and standards as well as provide clarification regarding roof coverings, masonry chimneys and plumbing systems constructed in accordance with the Kentucky Building Code.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Construction projects subject to the Kentucky Building Code will be affected by the amendments to this regulation; architects; engineers; contractors; project managers; businesses; and local government.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to comply with this administrative regulation or amendment: The identified entities must comply with the new amendments to the building code.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Affected entities are not anticipated to incur any substantial new expenses, as this amendment primarily corrects citations, typographical and formatting errors, and restores missing references to some preexisting standards. Moreover, increased expenses associated related to compliance with updated electrical and energy codes are anticipated to be minimal and subject to offset or pass through.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Benefits will include increased clarity of existing standards.

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

(a) Initially: There are no anticipated additional costs to administer these regulatory amendments.

(b) On a continuing basis: There are no anticipated additional costs to administer these regulatory amendments.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Implementation of these amendments is anticipated to result in no additional costs to the agency. Any agency costs resulting from these administrative amendments will be met with existing 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 amendment will not necessitate an increase in fees or require funding to the Department for implementation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: There are no fees directly or indirectly increased by this administrative regulation amendment.

(9) TIERING: Is tiering applied? Tiering is not applied as all builders, contractors, local governments and owners will be subject to the amended 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 of Housing, Buildings and Construction and local jurisdiction inspection and plan review programs.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. This regulation is authorized by KRS 198B.040(7) and KRS 198B.050. Moreover, the adoption of the 2012 International Energy Conservation Code is required by Section 304 of the Energy Conservation and Production Act, 42 U.S.C. 6833.

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 is not anticipated to generate additional revenues for the agency.

(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 is not anticipated to generate additional revenues for the agency.

(c) How much will it cost to administer this program for the first year? There are no anticipated additional costs to administer this regulatory amendment.

(d) How much will it cost to administer this program for subsequent years? There are no anticipated additional costs to administer this regulatory amendment.

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

Revenues (+/-): Neutral.

Expenditures (+/-): Neutral.

Other Explanation: Neutral.

PUBLIC PROTECTION CABINET
Department of Housing, Buildings and Construction
Division of Building Code Enforcement
(Amendment)

815 KAR 7:125. Kentucky Residential Code.

RELATES TO: KRS 132.010(9), (10), 198B.010, 198B.040, 198B.050, 198B.060, 198B.080, 198B.110, 198B.260, 198B.990, 227.550(7)

STATUTORY AUTHORITY: KRS 198B.040(7), 198B.050

NECESSITY, FUNCTION, AND CONFORMITY: KRS 198B.040(7) requires the Kentucky Board of Housing, Buildings and Construction to adopt and promulgate a mandatory uniform state building code, based on a model code, which establishes standards for construction of buildings in the state. This administrative regulation establishes the basic mandatory uniform statewide code provisions relating to construction of one (1) and two (2) family dwellings and townhouses.

Section 1. Definitions. (1) "Board of Housing" or "board" means the Kentucky Board of Housing, Buildings and Construction.

(2) "Building" is defined by KRS 198B.010(4).

(3) "Commissioner" means the commissioner of the Department of Housing, Buildings, and Construction.

(4) "Department" means the Department of Housing, Building, and Construction.

(5) "Farm" means property having a bona fide agricultural or horticultural use as defined by KRS 132.010(9) and (10) that is qualified by and registered with the property valuation administrator in the county in which the property is located.

(6) "KBC" means the Kentucky Building Code as established in 815 KAR 7:120.

(7) "Manufactured home" is defined by KRS 198B.010(23) and 227.550(7).

(8) "Modular home" means an industrialized building system, which is designed to be used as a residence and that is not a manufactured or mobile home.

(9) "Ordinary repair" is defined by KRS 198B.010(19).

(10) "Single-family dwelling" or "one-family dwelling" means a single unit providing complete independent living facilities for one (1) or more persons including permanent provisions for living, sleeping, eating, cooking, and sanitation, and which is not connected to any other unit or building.

(11) "Two (2) family dwelling" means a building containing not more than two (2) dwelling units that are connected.

Section 2. Mandatory Building Code Requirements for Dwellings. (1) Except as provided in subsection (2) of this section,

a single-family dwelling, two (2) family dwelling, or townhouse shall not be constructed unless it is in compliance with the 2012 International Residential Code for One (1) and Two (2) Family Dwellings, as amended by this administrative regulation and the 2013 Kentucky Residential Code.

(2) Exceptions.

(a) Permits, inspections, and certificates of occupancy shall not be required for a single-family dwelling unless required by a local ordinance.

(b) All residential occupancies that are not single-family, two (2) family[~~two-family~~], or townhouses shall comply with the 2012 International Building Code for One (1) and Two (2) Family Dwellings and the 2013 Kentucky Building Code.

(3) The 2012 International Residential Code for One (1) and Two (2) Family Dwellings shall be amended as established in the 2013 Kentucky Residential Code.

(4) Plans for single-family or one (1) family dwellings, two (2) family dwellings, and townhouses shall be designed and submitted to conform to this administrative regulation.

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

(a) "2012 International Residential Code for One (1) and Two (2) Family Dwellings," International Code Council, Inc.; and

(b) "2013 Kentucky Residential Code", Second Edition, February 2014[~~August 2013~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Housing, Buildings, and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky 40601-5412[~~5405~~], Monday through Friday, 8 a.m. to 4:30 p.m.

AMBROSE WILSON IV, Chairman
JACK COLEMAN, Deputy Commissioner
ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: April 7, 2014

FILED WITH LRC: April 8, 2014 at noon

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on Thursday, May 22, 2014, at 10:00 a.m., EDT, in the Department of Housing, Buildings and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky. Individuals interested in being heard at this hearing shall notify this agency in writing by Thursday, May 15, 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 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 the close of business on June 2, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation by the above date to the contact person:

CONTACT PERSON: Michael T. Davis, General Counsel, Department of Housing, Buildings and Construction, 101 Sea Hero Road, Suite 100, Frankfort, Kentucky 40601-5412, phone 502-573-0365 ext. 144, fax 502-573-1057.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Michael T. Davis

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the uniform Kentucky Residential Code as required pursuant to KRS 198B.050.

(b) The necessity of this administrative regulation: This administrative regulation is necessary in order to adopt the Kentucky Residential Code as required pursuant to KRS 198B.050.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation utilizes the International Residential Code as the basis for construction standards and allows the Board of Housing, Buildings and Construction to make amendments unique to Kentucky after due consideration of equivalent safety measures as required by KRS 198B.050.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The regulation sets forth standards authorized by the statute for the enforcement of the residential code, incorporating all applicable laws into its processes.

(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: Updates the 2013 Kentucky Residential Code to correct inadvertent typographical, citation and formatting errors that were not identified earlier this year when this administrative regulation was originally amended to establish the 2013 Kentucky Residential Code. In addition, this amendment corrects inadvertent omissions from the 2013 KRC to restore language that was adopted by the Board of Housing, Buildings and Construction during its May 2013 meeting but omitted as a result of drafting errors. These sections include the restoration of Section R802 (Wood Roof Framing), Chapter 11 (Energy Efficiency), and Appendix G (Swimming Pools), and the deletion of Chapter 33 (Storm Drainage). Also, this amendment reflects new amendments to Section R502 (Wood Floor Framing) and associated Table R602.3(1) to establish new safety provisions for the fastening of steel columns and beams. Finally, this amendment updates the KRC to adopt the 2014 edition of the National Electrical Code (NEC).

(b) The necessity of the amendment to this administrative regulation: To implement code changes originally approved by the Board of Housing, Buildings and Construction during its May 2013 meeting, December 2013 meeting, and February 2014 meeting.

(c) How the amendment conforms to the content of the authorizing statutes: KRS 198B mandates the Board of Housing, Buildings and Construction to establish a uniform Kentucky Building Code. These amendments were approved by the Board and by the Single Family Dwellings Advisory Committee to update, correct and amend the current 2013 Kentucky Residential Code.

(d) How the amendment will assist in the effective administration of the statutes: These amendments to the Kentucky Residential Code are intended to enhance public safety and to allow the construction industry to utilize an updated version of the model code and its referenced codes and standards as well as provide clarification regarding wood roof framing, swimming pools, and storm drainage constructed in accordance with the Kentucky Residential Code.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Construction projects subject to the Kentucky Residential Code will be affected by the amendments to this regulation; architects; engineers; contractors; project managers; businesses; and local government.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to comply with this administrative regulation or amendment: The identified entities must comply with the new amendments to the residential code.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Affected entities are not anticipated to incur any substantial new expenses, as this amendment primarily corrects citations, typographical and formatting errors, and restores missing references to some preexisting standards. Moreover, increased expenses associated related to compliance with updated electrical and energy codes are anticipated to be minimal and subject to offset or pass through.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Benefits will include increased clarity of existing standards.

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

this administrative regulation:

(a) Initially: There are no anticipated additional costs to administer these regulatory amendments.

(b) On a continuing basis: There are no anticipated additional costs to administer these regulatory amendments.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Implementation of these amendments is anticipated to result in no additional costs to the agency. Any agency costs resulting from these administrative amendments will be met with existing 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 amendment will not necessitate an increase in fees or require funding to the Department for implementation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: There are no fees directly or indirectly increased by this administrative regulation amendment.

(9) TIERING: Is tiering applied? Tiering is not applied as all builders, contractors, local governments and owners will be subject to the amended 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 of Housing, Buildings and Construction and local jurisdiction inspection and plan review programs.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. This regulation is authorized by KRS 198B.040(7) and KRS 198B.050.

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 is not anticipated to generate additional revenues for the agency.

(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 is not anticipated to generate additional revenues for the agency.

(c) How much will it cost to administer this program for the first year? There are no anticipated additional costs to administer this regulatory amendment.

(d) How much will it cost to administer this program for subsequent years? There are no anticipated additional costs to administer this regulatory amendment.

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

Revenues (+/-): Neutral.

Expenditures (+/-): Neutral.

Other Explanation: Neutral.

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

902 KAR 55:045. Exempt prescription products.

RELATES TO: KRS 218A.020-218A.250[~~218A.130~~], 21 C.F.R. 1308.31-1308.32

STATUTORY AUTHORITY: KRS[~~194A.030, 194A.050, 211.090,~~] 218A.020[~~, 218A.250~~]

NECESSITY, FUNCTION, AND CONFORMITY: KRS 218A.020(3) provides that if a controlled substance is designated, rescheduled, or deleted as a controlled substance under federal law and notice is given to the Cabinet for Health and Family Services, the Cabinet for Health and Family Services may similarly control the substance under KRS Chapter 218A by administrative regulation. This administrative regulation exempts prescription products from the licensing, distribution, recordkeeping, and reporting provisions of KRS Chapter 218A if the products have received approval as an exempt prescription product pursuant to 21 C.F.R. 1308.32[~~from the provisions of KRS Chapter 218A that stimulant or depressant products have been exempted pursuant to federal regulation~~].

Section 1. Exempt Prescription Products. The Cabinet for Health and Family Services exempts prescription products from the licensing, distribution, recordkeeping, and reporting provisions of KRS 218A.150 – 218A.172, 218A.180, 218A.200, and 218A.202 if the products have received approval as exempt prescription products pursuant to 21 C.F.R. 1308.32[~~the following prescription products from the provisions of KRS 218A.150 - 218A.180 and 218A.200:~~

~~(1) Acetaminophen 325mg/Butalbital 50 mg, tablet, NDC 00456-0674: butalbital 50 mg;~~

~~(2) Acetaminophen 500mg/Butalbital 50 mg, tablet, NDC 00456-0671: butalbital 50 mg;~~

~~(3) ALAGESIC Tablets, tablet, NDC 55726-0300: butalbital 50 mg;~~

~~(4) Alkaloids of Belladonna and Phenobarbital, tablet, NDC 00377-0527: phenobarbital 16.20 mg;~~

~~(5) Amaphen Capsules (reformulated), capsule, NDC 11311-0954: butalbital 50 mg;~~

~~(6) Aminophylline and Phenobarbital, enteric coated tablet, NDC 00115-2156: phenobarbital 15 mg;~~

~~(7) Aminophylline and Phenobarbital Tablets, tablet, NDC 00115-2154: phenobarbital 15 mg;~~

~~(8) Anaspaz PB, tablet, NDC 00225-0300: phenobarbital 15 mg;~~

~~(9) Anolor 300 Capsules, capsule, NDC 51674-0009: butalbital 50 mg;~~

~~(10) Anoquan Modified Formula, capsule, NDC 00166-0881: butalbital 50 mg;~~

~~(11) Anti-Spas Elixir, elixir, NDC 00719-4090: phenobarbital 3.24 mg/ml;~~

~~(12) Anti-Spas Tablets, tablet, NDC 00719-1091: phenobarbital 16.20 mg;~~

~~(13) Antispas, tablet, NDC 00377-0622: phenobarbital 16.20 mg;~~

~~(14) Antispasmodic, tablet, NDC 00364-0020: phenobarbital 16 mg;~~

~~(15) Antispasmodic, tablet, NDC 00367-4118: phenobarbital 16.20 mg;~~

~~(16) Antispasmodic, tablet, NDC 03547-0777: phenobarbital 16.20 mg;~~

~~(17) Antispasmodic Elixir, elixir, NDC 00182-0686: phenobarbital 3.24 mg/ml;~~

~~(18) Antispasmodic Elixir, elixir, NDC 00364-7002: phenobarbital 3.20 mg/ml;~~

~~(19) Antispasmodic Elixir, elixir, NDC 00832-8009: phenobarbital 3.24 mg/ml;~~

~~(20) Antispasmodic Tablets, tablet, NDC 00182-0129: phenobarbital 16.20 mg;~~

~~(21) Antispasmodic Tablets, tablet, NDC 47679-0158: phenobarbital 16.2 mg;~~

~~(22) Antispasmodic Tablets, tablet, NDC 00839-5055: phenobarbital 16 mg;~~

~~(23) Antrocol, capsule, NDC 00095-0041: phenobarbital 16 mg;~~

~~(24) Antrocol Elixir, elixir, NDC 00095-0042: phenobarbital 3 mg/ml;~~

~~(25) Antrocol Tablets, tablet, NDC 00095-0040: phenobarbital 16 mg;~~

~~(26) Arco-Lase Plus, tablet, NDC code 00275-0045: phenobarbital 8 mg;~~

~~(27) Atropine Sulfate with Phenobarbital, tablet, NDC 00463-6035: phenobarbital 15 mg;~~

~~(28) Axotal, tablet, NDC 00013-1301: butalbital 50 mg;~~

~~(29) Azpan, tablet, NDC 00172-3747: phenobarbital 8 mg;~~

~~(30) B-A-C Tablets, tablet, NDC 00259-1256: butalbital 50 mg;~~

~~(31) Bancap, capsule, NDC 00456-0546: butalbital 50 mg;~~

~~(32) Barbeloid (Revised) Green, tablet, NDC 00377-0365: phenobarbital 16.20 mg;~~

~~(33) Barbeloid Yellow, tablet, NDC 00377-0498: phenobarbital 16.20 mg;~~

~~(34) Barbidonna Elixir, elixir, NDC 00037-0305: phenobarbital 3.20 mg/ml;~~

~~(35) Barbidonna No 2, tablet, NDC 00037-0311: phenobarbital 32 mg;~~

~~(36) Barbidonna Tablets, tablet, NDC 00037-0301: phenobarbital 16 mg;~~

~~(37) Barophen, elixir, NDC 00472-0981: phenobarbital 3.24 mg/ml;~~

~~(38) Bel-phen-ergot s Tablets, tablet, NDC 00182-1847: phenobarbital 40 mg;~~

~~(39) Bel-Phen-Ergot-S Tablets, tablet, NDC 00719-1686: phenobarbital 40 mg;~~

~~(40) Bel-Tabs, tablet, NDC 00677-1171: phenobarbital 40 mg;~~

~~(41) Belladenal, tablet, NDC 00078-0028: phenobarbital 50 mg;~~

~~(42) Belladenal-S, sustained release tablet, NDC 00078-0027: phenobarbital 50 mg;~~

~~(43) Belladonna Alkaloids with Phenobarbital, elixir, NDC 00179-0045: phenobarbital 3.24 mg/ml;~~

~~(44) Belladonna Alkaloids with Phenobarbital, elixir, NDC 00737-1283: phenobarbital 3 mg/ml;~~

~~(45) Belladonna Alkaloids with Phenobarbital, tablet, NDC 51079-0168: phenobarbital 16.20 mg;~~

~~(46) Belladonna Alkaloids and Phenobarbital, tablet, NDC 00143-1140: phenobarbital 16.20 mg;~~

~~(47) Bellalphen, tablet, NDC 00223-0425: phenobarbital 16.20 mg;~~

~~(48) Bellamine Tablets, tablet, NDC 00904-2548: phenobarbital 40 mg;~~

~~(49) Bellamor Tablets, tablet, NDC 00839-7370: phenobarbital 40 mg;~~

~~(50) Bellergal-S, sustained release tablet, NDC 00078-0031: phenobarbital 40 mg;~~

~~(51) Bellophen, tablet, NDC 00115-2400: phenobarbital 16.20 mg;~~

~~(52) Bilezyme Plus, tablet, NDC 00249-1112: phenobarbital 8 mg;~~

~~(53) Bladder Mixture Plus Phenobarbital, liquid, NDC 11326-1624: phenobarbital 2.92 mg/ml;~~

~~(54) Blue Cross Butalbital, APAP and Caffeine Tablets, tablet, NDC 00879-0567: butalbital 50 mg;~~

~~(55) Broncholate, capsule, NDC 00563-0277: phenobarbital 8 mg;~~

~~(56) Broncomar, elixir, NDC 12939-0128: butabarbital 1 mg/ml;~~

~~(57) Bucet Capsules, capsule, NDC 00785-2307: butalbital 50 mg;~~

~~(58) Bucet Tablets, tablet, NDC 00785-2307: butalbital 50 mg;~~

~~(59) Butace, capsule, NDC code 00539-0906: butabarbital 50 mg;~~

~~(60) Butacet Capsules, capsule, NDC 53121-0133: butalbital 50 mg;~~

~~(61) Butalbital, Acetaminophen and Caffeine Capsules, capsule, NDC 46672-0228: butalbital 50 mg;~~

~~(62) Butalbital, Acetaminophen and Caffeine Tablets, tablet, NDC 52555-0079: butalbital 50 mg;~~

~~(63) Butalbital, Acetaminophen and Caffeine Tablets, tablet, NDC 54696-0513: butalbital 50 mg~~

~~(64) Butalbital, Acetaminophen and Caffeine Tablets, tablet, NDC 00302-0490: butalbital 50 mg;~~

~~(65) Butalbital, Acetaminophen and Caffeine Tablets, tablet, NDC 46672-0053: butalbital 50 mg;~~

~~(66) Butalbital, Acetaminophen and Caffeine Tablets, tablet, NDC 46672-0059: butalbital 50 mg;~~

~~(67) Butalbital, Acetaminophen and Caffeine Tablets, tablet, NDC 00832-1102: butalbital 50 mg;~~

~~(68)Butalbital, Acetaminophen and Caffeine Tablets, tablet, NDC 52446-0544: butalbital 50 mg;~~

~~(69) Butalbital and Acetaminophen Tablets, tablet, NDC 00879-0543: butalbital 50 mg;~~

~~(70) Butalbital and Acetaminophen Tablets 50/325, tablet, NDC 46672-0099: butalbital 50 mg;~~

~~(71) Butalbital and Acetaminophen Tablets 50/650, tablet, NDC 46672-0098: butalbital 50 mg;~~

~~(72) Butalbital, APAP and Caffeine, tablet, NDC 00302-0490: butalbital 50 mg;~~

~~(73) Butalbital, APAP and Caffeine Tablets, tablet, NDC 00182-1274: butalbital 50 mg;~~

~~(74) Butalbital Compound Capsules, capsule, NDC 53506-0103: butalbital 50 mg;~~

~~(75) Butalbital with Acetaminophen and Caffeine Tablets, tablet, NDC 00143-1787: butalbital 50 mg;~~

~~(76) Butibel Elixir, elixir, NDC 00037-0044: butabarbital sodium 3 mg/ml;~~

~~(77) Butibel Tablets, tablet, NDC 00037-0046: butabarbital sodium 15 mg;~~

~~(78) Cafatine-PB Tablets, tablet, NDC 00904-1750: pentobarbital sodium 30 mg;~~

~~(79) Cafergot P-B Suppository, suppository, NDC 00078-0035: pentobarbital 60 mg;~~

~~(80) Cafergot P-B Tablets, tablet, NDC 00078-0036: pentobarbital sodium 30 mg;~~

~~(81) C.D.P. Plus Capsules, capsule, NDC 00182-1856: chlordiazepoxide HCl 5 mg;~~

~~(82) Cephadyn, tablet, NDC 95702-0650: butalbital 50 mg.;~~

~~(83) Charspast, tablet, NDC 00377-0500: phenobarbital 16.20 (83) mg;~~

~~(84) Chlordiazepoxide HCl and Clidinium Br., capsule, NDC 57247-1003: chlordiazepoxide 5 mg;~~

~~(85) Chlordiazepoxide HCl 5 mg and Clidinium BR 2.5 mg, capsule, NDC 52446-0096: chlordiazepoxide HCL 5 mg;~~

~~(86) Chlordiazepoxide Hydrochloride + Clidinium Bromide, capsule, NDC 47679-0268: chlordiazepoxide HCl 5 mg;~~

~~(87) Chlordiazepoxide with Clidinium Bromide, capsule, NDC 46193-0948: chlordiazepoxide HCl 5 mg;~~

~~(88) Chlordinium, capsule, NDC 00719-1208: chlordiazepoxide HCl 5 mg;~~

~~(89) Chlordinium Sealets, capsule, NDC 00580-0084: chlordiazepoxide HCl 5 mg;~~

~~(90) Clindex, capsule, NDC 00536-3490: chlordiazepoxide HCL 5 mg;~~

~~(91) Clinibrax Capsules, capsule, NDC 00832-1054: chlordiazepoxide HCl 5 mg;~~

~~(92) Clinoxide, capsule, NDC 00879-0501: chlordiazepoxide HCl 5 mg;~~

~~(93) CON-TEN, capsule, NDC 11584-1029: butalbital 50 mg;~~

~~(94) Digestokraft, tablet, NDC 00796-0237: butabarbital sodium 8 mg;~~

~~(95) Digestokraft, tablet, NDC 00377-0460: butabarbital sodium 8 mg;~~

~~(96) Dilantin with Phenobarbital 1/2,capsule, NDC 00071-0531: phenobarbital 32 mg;~~

~~(97) Dilantin with Phenobarbital 1/4, capsule, NDC 00071-0375: phenobarbital 16 mg;~~

~~(98) Dolmar, capsule, NDC 12939-0812: butalbital 50 mg;~~

~~(99) Donalixir, elixir, NDC 00471-0095: phenobarbital 3.24 mg/ml;~~

~~(100) Donna-Sed, elixir, NDC 00298-5054: phenobarbital 3.24 mg/ml;~~

~~(101) Donnatal Capsules, capsule, NDC 00031-4207: phenobarbital 16.20 mg;~~

~~(102) Donnatal Elixir, elixir, NDC 00031-4221: phenobarbital 3.24 mg/ml;~~

~~(103) Donnatal Extentabs, sustained release tablet, NDC 00031-4235: phenobarbital 48.60 mg;~~

~~(104) Donnatal No 2, tablet, NDC 00031-4264: phenobarbital 32.40 mg;~~

~~(105) Donnatal Tablets, tablet, NDC 00031-4250: phenobarbital 16.20 mg;~~

~~(106) Donnazyme, enteric coated tablet, NDC 00031-4649: phenobarbital 8.10 mg;~~

~~(107) Donphen, tablet, NDC 00093-0205: phenobarbital 15 mg;~~

~~(108) E-Caff PB Tablets, tablet, NDC 00185-0982: pentobarbital 30 mg;~~

~~(109) Endolar, capsule, NDC 00588-7777: butalbital 50 mg;~~

~~(110) Ephedrine and Sodium Phenobarbital, tablet, NDC 00377-0109: phenobarbital sodium 16.20 mg;~~

~~(111) Ephedrine with Phenobarbital, tablet, NDC 00463-6086: phenobarbital 15 mg;~~

~~(112) EQUI-CET Tablets, tablet, NDC 57779-0111: butalbital 50 mg;~~

~~(113) Ergocaff-PB Tablets, tablet, NDC 00536-3801: pentobarbital sodium 30 mg;~~

~~(114) Esgic Capsules, capsule, NDC 00456-0631: butalbital 50 mg;~~

~~(115) ESGIC-PLUS, NDC 00456-0676, tablet, contains butalbital 50 mg;~~

~~(116) Esgic Tablets, tablet, NDC 0456-0630: butalbital 50 mg;~~

~~(117) Espasmotex, tablet, NDC code 11475-0835: phenobarbital 20 mg;~~

~~(118) Ezol, capsule, NDC 45985-0578: butalbital 50 mg;~~

~~(119) Fabophen Tablets, tablet, NDC 00904-3280: butalbital 50 mg;~~

~~(120) Febridyne Plain Capsules, capsule, NDC 05383-0001: butalbital 50 mg;~~

~~(121) FEMCET Capsules, capsule, NDC 50474-0703: butalbital 50 mg;~~

~~(122) Fioricet, capsule, NDC 00078-0084: butalbital 50 mg;~~

~~(123) G-1 Capsules, capsule, NDC 43797-0244: butalbital 50 mg;~~

~~(124) G.B.S., tablet, NDC 00456-0281: phenobarbital 8 mg;~~

~~(125) Gustase Plus, tablet, NDC 00249-1121: phenobarbital 8 mg;~~

~~(126) Hybephen, tablet, NDC 00029-2360: phenobarbital 15 mg;~~

~~(127) Hyosital White, tablet, NDC 00361-2131: phenobarbital 16.20 mg;~~

~~(128) Hyosophen Capsules, capsule, NDC 00536-3926: phenobarbital 16 mg;~~

~~(129) Hyosophen Tablets, tablet, NDC 00536-3920: phenobarbital 16.20 mg;~~

~~(130) Hypnaldyne, tablet, NDC 00298-1778: phenobarbital 16.20 mg;~~

~~(131) Hytrophen, tablet, NDC 00917-0244: phenobarbital 16.20 mg;~~

~~(132) IDE-Cet Tablets, tablet, NDC 00814-3820: butalbital 50 mg;~~

~~(133) ISOCET Tablets, tablet, NDC 00536-3951: butalbital 50 mg;~~

~~(134) Isolate Compound, elixir, NDC 00472-0929: phenobarbital 0.40 mg/ml;~~

~~(135) Isolate Compound Elixir, elixir, NDC 00364-7029: phenobarbital 0.40 mg/ml;~~

~~(136) Isopap Capsules, capsule, NDC 11735-0400: butalbital 50 mg;~~

~~(137) Isophed, liquid, NDC 00298-5680: phenobarbital 0.40 mg/ml;~~

~~(138) Isuprel, elixir, NDC 00024-0874: phenobarbital 0.40 mg/ml;~~

~~(139) Isuprel Compound, elixir, NDC 00057-0874: phenobarbital 0.40 mg/ml;~~

~~(140) Kinesed, tablet, NDC 00038-0220: phenobarbital 16 mg;~~

~~(141) Levsin with Phenobarbital Elixir, elixir, NDC 00091-4530: phenobarbital 3 mg/ml;~~

~~(142) Levsin with Phenobarbital Tablets, tablet, NDC 00091-3534: phenobarbital 15 mg;~~

~~(143) Levsin-PB, drops, NDC 00091-4536: phenobarbital 15 mg/ml;~~

~~(144) Levsinex with Phenobarbital, sustained release capsule, NDC 00091-3539: phenobarbital 45 mg;~~

~~(145) Librax, capsule, NDC 00140-0007: chlordiazepoxide HCl 5 mg;~~

~~(146) Lufyllin-EPG Elixir, elixir, NDC 00037-0565: phenobarbital 1.60 mg/ml;~~

~~(147) Lufyllin-EPG Tablets, tablet, NDC 00037-0561: phenobarbital 16 mg;~~

~~(148) Malatal, tablet, NDC 00166-0748: phenobarbital 16.20 mg;~~

~~(149) Margesic Capsules, capsule, NDC 00682-0804: butalbital 50 mg;~~

~~(150) Medigesic Tablets, tablet, NDC 52747-0311: butalbital 50 mg;~~

~~(151) Menrium 5-2, tablet, NDC 00140-0023: chlordiazepoxide 5 mg;~~

~~(152) Menrium 5-4, tablet, NDC 00140-0024: chlordiazepoxide 5 mg;~~

~~(153) Menrium 10-4, tablet, NDC 00140-0025: chlordiazepoxide 10 mg;~~

~~(154) Micomp-PB Tablets, tablet, NDC 55053-0525: pentobarbital sodium 30 mg;~~

~~(155) Milprem-200, tablet, NDC 00037-5501: meprobamate 200 mg;~~

~~(156) Milprem-400, tablet, NDC 00037-5401: meprobamate 400 mg;~~

~~(157) Mudrane, tablet, NDC 00095-0050: phenobarbital 8 mg;~~

~~(158) Mudrane GG Elixir, elixir, NDC 00095-0053: phenobarbital 0.50 mg/ml;~~

~~(159) Mudrane GG Tablets, tablet, NDC 00095-0051: phenobarbital 8 mg;~~

~~(160) Pacaps Capsules, capsule, NDC 10892-0116: butalbital 50 mg;~~

~~(161) Pacaps Modified Formula, capsule, NDC 48534-0884: butalbital 50 mg;~~

~~(162) Panzyme, tablet, NDC 00377-0491: phenobarbital 8.10 mg;~~

~~(163) Panzyme, tablet, NDC 00314-0310: phenobarbital 8.10 mg;~~

~~(164) PB Phe-Bell, tablet, NDC 12908-7006: phenobarbital 16.20 mg;~~

~~(165) Phedral C.T., tablet, NDC 00298-1173: phenobarbital 8.10 mg;~~

~~(166) Phenerbel-S Tablets, tabelt, NDC 00536-4234: phenobarbital 40 mg;~~

~~(167) Phenobarbital, Ergotamine and Belladonna Tablets, tablet, NDC 00781-1701: phenobarbital 40 mg;~~

~~(168) Phenobarbital and Hyoscyamine Sulfate, tablet, NDC 00764-2057: phenobarbital 16.20 mg;~~

~~(169) Phrenilin, tablet, NDC 00086-0050: butalbital 50 mg;~~

~~(170) Phrenilin Forte, capsule, NDC 00086-0056: butalbital 50 mg;~~

~~(171) PMB-200, tablet, NDC 00046-0880: meprobamate 200 mg;~~

~~(172) PMB-400, tablet, NDC 00046-0881: meprobamate 400 mg;~~

~~(173) Private Formula No 3095, tablet, NDC 00252-3095: phenobarbital sodium 15 mg;~~

~~(174) Pulsaphen, tablet, NDC 00377-0652: phenobarbital 15 mg;~~

~~(175) Pulsaphen Gray, tablet, NDC 00917-0113: phenobarbital 15 mg;~~

~~(176) Quadrinal Suspension, suspension, NDC 00044-4580: phenobarbital 2.40 mg/ml;~~

~~(177) Quadrinal Tablets, tablet, NDC 00044-4520: phenobarbital 24 mg;~~

~~(178) Quibron Plus Capsules, capsule, NDC 00087-0518: butabarbital 20 mg;~~

~~(179) Quibron Plus Elixir, elixir, NDC 00087-0511: butabarbital 1.33 mg/ml;~~

~~(180) Repan Capsules, capsule, NDC 00642-0163: butalbital 50 mg;~~

~~(181) Repan Tablets, tablet, NDC 00642-0162: butalbital 50~~

~~mg;~~

~~(182) Rexatal Tablets, tablet, NDC 00478-5477: phenobarbital 16.52 mg;~~

~~(183) Rogesic Capsules, capsule, NDC 31190-0008: butalbital 50 mg;~~

~~(184) Sangesic, tablet, NDC 00511-1627: butalbital 30 mg;~~

~~(185) Sedapap-10 Tablets, tablet, NDC 00259-1278: butalbital 50 mg;~~

~~(186) Sedapar Elixir, elixir, NDC 00349-4100: phenobarbital 3.24 mg/ml;~~

~~(187) Sedapar Tablets, tablet, NDC 00349-2355: phenobarbital 16.20 mg;~~

~~(188) Sedarex No 3, tablet, NDC 00144-1575: phenobarbital 16.20 mg;~~

~~(189) Seds, tablet, NDC 00418-4072: phenobarbital 16.20 mg;~~

~~(190) Soniphen, enteric coated tablet, NDC 0456-0429: phenobarbital 16 mg;~~

~~(191) Spaslin, tablet, NDC 00165-0029: phenobarbital 16.20 mg;~~

~~(192) Spasmalones, tablet, NDC 00653-0002: phenobarbital 16 mg;~~

~~(193) Spasmolin, tablet, NDC 00115-4652: phenobarbital 15 mg;~~

~~(194) Spastemms Elixir, elixir, NDC 00463-9023: phenobarbital 3.24 mg/ml;~~

~~(195) Spastemms Tablets, tablet, NDC 0463-6181: phenobarbital 15 mg;~~

~~(196) Spastolate, tablet, NDC 00814-7088: phenobarbital 16.20 mg;~~

~~(197) Spastrin Tablets, tablet, NDC 54580-0124: phenobarbital 40 mg;~~

~~(198) Susano, elixir, NDC 00879-0059: phenobarbital 3.24 mg/ml;~~

~~(199) Susano, tablet, NDC 00879-0058: phenobarbital 16.20 mg;~~

~~(200) Tedral SA, sustained release tablet, NDC 00071-0231: phenobarbital 25 mg;~~

~~(201) Tencet, tablet, NDC 47649-0370: butalbital 50 mg;~~

~~(202) Tencet Capsules, capsule, NDC 47649-0560: butalbital 50 mg;~~

~~(203) T-E-P, tablet, NDC 00364-0266: phenobarbital 8.10 mg;~~

~~(204) T.E.P., tablet, NDC 00157-0980: phenobarbital 8 mg;~~

~~(205) Theodrine Tablets, tablet, NDC 00536-4648: phenobarbital 8 mg;~~

~~(206) Theophen, tablet, NDC code 12634-0101: phenobarbital 8 mg;~~

~~(207) Theophenyllin, tablet, NDC 00839-5111: phenobarbital 8 mg;~~

~~(208) Theophylline Ephedrine and Phenobarbital, tablet, NDC 00143-1695: phenobarbital 8 mg;~~

~~(209) Triad, tablet, NDC 00785-2306: butalbital 50 mg;~~

~~(210) Triad Capsules, capsule, NDC 00785-2305: butalbital 50 mg;~~

~~(211) Triaprin, capsule, NDC 00217-2811: butalbital 50 mg;~~

~~(212) Truxaphen, tablet, NDC 00377-0541: phenobarbital 16.20 mg;~~

~~(213) Two-Dyne Revised, tablet, NDC 00314-2229: butalbital 50 mg;~~

~~(214) Wescophen-S, tablet, NDC 00917-0135: phenobarbital 30 mg;~~

~~(215) Wescophen S-II, tablet, NDC 00377-0628: phenobarbital 30 mg;~~

~~(216) Wesmatic Forte, tablet, NDC 00917-0845: phenobarbital 8 mg;~~

~~(217) Wesmatic Forte, tablet, NDC 00377-0426: phenobarbital 8.10 mg; and~~

~~(218) Zebutal, capsule, NDC 59630-0170: butalbital 50~~].

CONNIE PAYNE, Acting Executive Director
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 11, 2014

FILED WITH LRC: April 11, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 21, 2014, at 9:00 a.m. in Auditorium A, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by May 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 close of business, June 2, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Connie Payne, Stephanie Hold, Stephanie Brammer-Barnes

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation exempts prescription products from the licensing, distribution, recordkeeping, and reporting provisions of KRS Chapter 218A if the products have been exempted by the Drug Enforcement Administration (DEA) from the application of certain provisions of the federal Controlled Substances Act pursuant to 21 C.F.R. 1308.32.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to exempt certain prescription products from the licensing, distribution, recordkeeping, and reporting provisions of KRS Chapter 218A.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 218A.020 by establishing Kentucky's exempt prescription products.

(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's exempt prescription products.

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

(a) How the amendment will change this existing administrative regulation: This amendment deletes the obsolete list of exempt prescription products in Kentucky, and adds language to clarify that those prescription products which are exempt from the licensing, distribution, recordkeeping, and reporting provisions of KRS Chapter 218A shall be the same products that have received approval from the DEA for exemption from the application of certain provisions of the federal Controlled Substances Act pursuant to 21 C.F.R. 1308.32.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure consistency between state and federal regulations which exempt certain prescription products from the licensing, distribution, recordkeeping, and reporting provisions of the state and federal Controlled Substances Acts.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by ensuring consistency between state and federal regulations related to exempt prescription products.

(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the statutes by ensuring consistency between this administrative regulation and 21 C.F.R 1308.32.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this

administrative regulation: This amendment affects Kentucky's pharmacists who rely on state and federal regulations for information regarding exempt prescription products.

(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: Under this amendment, Kentucky's pharmacists will use the DEA's most current Exempt Prescription Products List to ensure compliance with both this administrative regulation and federal regulations.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): By making Kentucky's exempt prescription products list consistent with the DEA's exempt prescription products list, this amendment reduces confusion for pharmacists who rely on state and federal regulations for such information.

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

(a) Initially: No costs are necessary to implement this amendment.

(b) On a continuing basis: No costs are necessary to implement this amendment.

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

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish or increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applicable as compliance with this administrative regulation applies equally to all individuals or entities who elect to be 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 Kentucky's pharmacists who rely on state and federal regulations for information regarding exempt prescription products.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 218A.020, 21 C.F.R. 1308.31-1308.32

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 additional revenue for state or local government during the first year.

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

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

(d) How much will it cost to administer this program for subsequent years? No additional costs are necessary to administer this program for subsequent years.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 21 C.F.R. 1308.31-1308.32

2. State compliance standards. KRS 218A.020(3)

3. Minimum or uniform standards contained in the federal mandate. 21 C.F.R. 1308.31 provides an application procedure whereby any person may apply for exemption for non narcotic prescription products which meet certain criteria. 21 C.F.R. 1308.31(a) further states that any person seeking to have any compound, mixture, or preparation containing any non narcotic controlled substance listed in 21 C.F.R. 1308.12(e), or in 21 C.F.R. 1308.13(b) or (c), or in 21 C.F.R. 1308.14, or in 21 C.F.R. 1308.15, exempted from application of all or any part of the federal Controlled Substances Act may apply to the Administrator of DEA for such exemption. 21 C.F.R. 1308.32 provides for a list of "exempted prescription products", which are prescription drugs that contain certain non narcotic controlled substances yet are exempt from certain provisions of the federal Controlled Substances Act.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Not applicable.

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

902 KAR 55:090. Exempt anabolic steroid products.

RELATES TO: KRS 218A.010-218A.250[~~218A.030, 218A.080-218A.090~~], 21 C.F.R. 1308.13, 1308.33-1308.34, 21 U.S.C. 801, 812

STATUTORY AUTHORITY: KRS 218A.020

NECESSITY, FUNCTION, AND CONFORMITY: KRS 218A.020 authorizes the Cabinet for Health and Family Services to add, delete, or reschedule substances enumerated in KRS Chapter 218A. This administrative regulation exempts certain anabolic steroid products from the licensing, distribution,[~~and~~] recordkeeping, and reporting provisions of KRS Chapter 218A if the products have received approval as an exempt anabolic steroid product pursuant to 21 C.F.R. 1308.34.

Section 1. Exempt Anabolic Steroid Products. The Cabinet for Health and Family Services exempts anabolic steroid products from the licensing, distribution, recordkeeping, and reporting provisions of KRS 218A.150 – 218A.172, 218A.180, 218A.200, and 218A.202 if the products have received approval as exempt anabolic steroid products pursuant to 21 C.F.R. 1308.34[~~the following anabolic steroid containing compounds, mixtures, or preparations from the provisions of KRS 218A.150 – 218A.180 and 218A.200: (1) Androgyn L.A.®, vial, NDC number 0456-1005: testosterone enanthate 90 mg/ml, estradiol valerate 4 mg/ml;~~

~~(2) Andro-Estro 90-4®, vial, NDC number 0536-1605: testosterone enanthate 90 mg/ml, estradiol valerate 4 mg/ml;~~

~~(3) Component E-H® in process granulation, pail or drum:~~

~~testosterone propionate 10 parts, estradiol benzoate 1 part;~~

~~(4) Component E-H® in process pellets, pail: testosterone propionate 25 mg, estradiol benzoate 2.5 mg/pellet;~~

~~(5) Component TE-S® in process granulation, pail or drum: trenbolone acetate 5 parts, estradiol USP 1 part;~~

~~(6) Component TE-S® in process pellets, pail: trenbolone acetate 120 mg, estradiol USP 24 mg/pellet;~~

~~(7) DepANDROGYN®, vial, NDC number 0456-1020: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(8) DEPO-T.E.®, vial, NDC number 52765-257: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(9) Depo-Testadiol®, vial, NDC number 0009-0253; testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(10) depTESTROGEN®, vial, NDC number 51698-257: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(11) Duomone®, vial, NDC number 52047-360: testosterone enanthate 90 mg/ml, estradiol valerate 4 mg/ml;~~

~~(12) DURATESTRIN®, vial, NDC number 43797-016: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(13) DUO-SPAN II®, vial, NDC number 0684-0102: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(14) Estratest®, tablet, NDC number 0032-1026: esterified estrogens 1.25 mg, methyltestosterone 2.5 mg;~~

~~(15) Estratest HS®, tablet, NDC number 0032-1023: esterified estrogens 0.625 mg, methyltestosterone 1.25 mg;~~

~~(16) Menogen®, tablet, NDC number 59243-0570: esterified estrogens 1.25 mg, methyltestosterone 2.5 mg.;~~

~~(17) Menogen HS®, tablet, NDC number 59243-0560: esterified estrogens 0.625 mg, methyltestosterone 1.25 mg.;~~

~~(18) PAN ESTRA TEST®, vial, NDC number 0525-0175: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(19) Premarin with Methyltestosterone®, tablet, NDC number 0046-0879: conjugated estrogens 1.25 mg, methyltestosterone 10.0 mg;~~

~~(20) Premarin with Methyltestosterone®, tablet, NDC number 0046-0878: conjugated estrogens 0.625 mg, methyltestosterone 5.0 mg;~~

~~(21) Synovex H in-process bulk pellets, drum: testosterone propionate 25 mg., estradiol benzoate 2.5 mg.;~~

~~(22) Synovex H Pellets in-process granulation, drum: testosterone propionate 10 parts, estradiol benzoate 1 part;~~

~~(23) Synovex Plus®, in-process bulk pellets, drum: trenbolone acetate 25 mg., estradiol benzoate 3.5 mg/pellet;~~

~~(24) Synovex Plus®, in-process ganulation, drum: trenbolone acetate 25 parts, estradiol benzoate 3.5 parts;~~

~~(25) TEST-ESTRO Cypionates®, vial, NDC number 0536-9470: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(26) Testagen®, vial, NDC number 55553-257: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(27) Testoderm®, 4 mg/d, patch, NDC number 17314-4608: testosterone 10 mg.;~~

~~(28) Testoderm®, 6 mg/d, patch, NDC number 17314-4609: testosterone 15 mg.;~~

~~(29) Testoderm®, with Adhesive, 4 mg/d, patch, export only: testosterone 10 mg;~~

~~(30) Testoderm®, with Adhesive, 6 mg/d, patch, NDC number 17314-2836: testosterone 15 mg.;~~

~~(31) Testoderm®, in-process film, sheet: testosterone 0.25 mg/cm²;~~

~~(32) Testoderm®, with Adhesive, in-process film, sheet: testosterone 0.25 mg/cm²;~~

~~(33) Testosterone Cyp 50 Estradiol Cyp 2, vial, NDC number 0814-7737: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(34) Testosterone Cypionate-Estradiol Cypionate Injection, vial, NDC number 54274-530: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(35) Testosterone Cypionate-Estradiol Cypionate Injection, vial, NDC number 0182-3069: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(36) Testosterone Cypionate-Estradiol Cypionate Injection, vial, NDC number 0364-6611: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(37) Testosterone Cypionate-Estradiol Cypionate Injection, vial, NDC number 0402-0257: testosterone cypionate 50 mg/ml, estradiol cypionate 2 mg/ml;~~

~~(38) Testosterone Enanthate-Estradiol Valerate Injection, vial, NDC number 0182-3073: testosterone enanthate 90 mg/ml, estradiol valerate 4 mg/ml;~~

~~(39) Testosterone Enanthate-Estradiol Valerate Injection, vial, NDC number 0364-6618: testosterone enanthate 90 mg/ml, estradiol valerate 4 mg/ml;~~

~~(40) Testosterone Enanthate-Estradiol Valerate Injection, vial, NDC number 0402-0360: testosterone enanthate 90 mg/ml, estradiol valerate 4 mg/ml;~~

~~(41) Testosterone Ophthalmic Solutions, ophthalmic solutions: testosterone <0.6%w/v;~~

~~(42) Tilapia Sex Reversal Feed (Investigational), Rangen, Inc., plastic bags: methyltestosterone 60 mg/kg fish feed; and~~

~~(43) Tilapia Sex Reversal Feed (Investigational), Zeigler Brothers, Inc, plastic bags: methyltestosterone 60 mg/kg fish feed.~~]

CONNIE PAYNE, Acting Executive Director
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 11, 2014

FILED WITH LRC: April 11, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 21, 2014, at 9:00 a.m. in Auditorium A, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by May 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 close of business, June 2, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Persons: Connie Payne, Stephanie Hold, Stephanie Brammer-Barnes

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation exempts certain anabolic steroid products from the licensing, distribution, recordkeeping, and reporting provisions of KRS Chapter 218A if the products have been exempted by the Drug Enforcement Administration (DEA) from the application of certain provisions of the federal Controlled Substances Act pursuant to 21 C.F.R. 1308.34.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to exempt certain prescription products from the licensing, distribution, recordkeeping, and reporting provisions of KRS Chapter 218A.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 218A.020 by establishing Kentucky's exempt anabolic steroid products.

(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's exempt anabolic steroid products.

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

(a) How the amendment will change this existing administrative regulation: This amendment deletes the obsolete list of exempt anabolic steroid products in Kentucky, and adds language to clarify that those anabolic steroid products which are exempt from the licensing, distribution, recordkeeping, and reporting provisions of KRS Chapter 218A shall be the same products that have received approval from the DEA for exemption from the application of certain provisions of the federal Controlled Substances Act pursuant to 21 C.F.R. 1308.34.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure consistency between state and federal regulations which exempt certain anabolic steroid products from the licensing, distribution, recordkeeping, and reporting provisions of the state and federal Controlled Substances Acts.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by ensuring consistency between state and federal regulations related to exempt anabolic steroid products.

(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the statutes by ensuring consistency between this administrative regulation and 21 C.F.R 1308.34.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This amendment affects Kentucky's pharmacists who rely on state and federal regulations for information regarding exempt anabolic steroid products.

(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: Under this amendment, Kentucky's pharmacists will use the DEA's most current Exempt Anabolic Steroid Products List to ensure compliance with both this administrative regulation and federal regulations.

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

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): By making Kentucky's exempt anabolic steroid products list consistent with the DEA's exempt anabolic steroid products list, this amendment reduces confusion for pharmacists who rely on state and federal regulations for such information.

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

(a) Initially: No costs are necessary to implement this amendment.

(b) On a continuing basis: No costs are necessary to implement this amendment.

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

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish or increase any fees.

(9) TIERING: Is tiering applied? Tiering is not applicable as compliance with this administrative regulation applies equally to all individuals or entities who elect to be 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 Kentucky's pharmacists who rely on state and federal regulations for information regarding exempt anabolic steroid products.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 218A.020, 21 C.F.R. 1308.33-1308.34

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 additional revenue for state or local government during the first year.

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

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

(d) How much will it cost to administer this program for subsequent years? No additional costs are necessary to administer this program for subsequent years.

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate.

21 C.F.R. 1308.33-1308.34

2. State compliance standards. KRS 218A.020(3)

3. Minimum or uniform standards contained in the federal mandate. 21 C.F.R. 1308.33 provides an application procedure whereby any person may apply for exemption for anabolic steroid products which meet certain criteria. 21 C.F.R. 1308.33(a) further states that the Administrator of the DEA may exempt from the application of all or any part of the federal Controlled Substances Act any compound, mixture, or preparation containing an anabolic steroid which is intended for administration to a human being or animal, if, because of its concentration, preparation, formulation, or delivery system, it has no significant potential for abuse. 21 C.F.R. 1308.34 establishes the list of anabolic steroid products which are exempt from all or part of the federal Controlled Substances Act.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Not applicable.

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Income Support
Child Support Enforcement
(Amendment)

921 KAR 1:430. Child support administrative hearings.

RELATES TO: KRS Chapter 13B, 15.055, 154A.060(2)(g), 205.710, 205.712, 205.745, 205.7685, 205.769, 205.778, 237.110(4)(f), 341.392, 341.420, 405.411, 405.440(4), 405.450(5), 405.463, 405.465, 405.467, 405.470, 405.490(4)

STATUTORY AUTHORITY: KRS 13B.170, 194A.050(1), 205.712, 45 C.F.R. 303.35, 42 U.S.C. 666

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, qualify for the receipt of federal funds, or to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs. 42 U.S.C. 666 requires each state to have in effect procedures to increase the effectiveness of the Child Support Enforcement Program. 45 C.F.R. 303.35 requires the agency administering the Child Support Enforcement Program to develop a procedure for administrative reviews of child support cases for individuals with complaints. KRS 13B.170 authorizes an agency to promulgate administrative regulations that are necessary to carry out the provisions of KRS Chapter 13B. This administrative regulation establishes the administrative hearing procedures used by the cabinet in the administration of the Child Support Enforcement Program.

Section 1. Availability of a Hearing. (1) An opportunity for an administrative hearing shall be provided to an individual aggrieved by an action or inaction:

(a) On the part of the Child Support Enforcement Program; and

(b) That affects the child support case of the individual.

(2) An individual requesting an administrative hearing shall have the option to designate a representative to act on behalf of the aggrieved party for the hearing process, such as:

(a) Legal counsel;

(b) A relative; or

(c) Any other person.

(3) An administrative hearing shall be conducted by an administrative hearing officer assigned by the Division of Administrative Hearings, Families and Children Administrative Hearings Branch:

(a) In the county of residence for the appellant or child; or

(b) By telephone or at an alternate location, if the appellant:

1. Is unable to travel; and

2. Requests alternate hearing arrangements at least five (5) calendar days in advance of the scheduled hearing.

(4) If the appellant or authorized representative speaks a language other than English, the cabinet shall ensure that interpreter services are provided for the administrative hearing.

(5) Child support enforcement staff shall schedule and hold an informal interview or conference with an aggrieved individual:

(a) Within ten (10) calendar days of receiving the individual's hearing request;

(b) Prior to an administrative hearing being scheduled; and

(c) To attempt resolution of the dispute.

(6) If the informal conference does not resolve the issue, the hearing request shall be sent to the Families and Children Administrative Hearings Branch as specified in Section 2 of this administrative regulation for scheduling.

Section 2. Request for a Hearing. (1) An individual shall request an administrative hearing by:

(a) Completing and submitting a CS-180, Request for Administrative Hearing;

(b) Submitting a written request; or

(c) Making an oral request, which is then transferred into a written request within the timeframes specified in subsection (4) of this section.

(2) An administrative hearing request shall be submitted to the:

(a) Child support contracting official's office in the appellant's county of residence; or

(b) Child Support Enforcement's central office.

(3) The count of days specified in subsection (4) of this section shall begin from the date of:

(a) Issuance, if the notice is sent by first class mail; or

(b) Receipt, if the notice is personally served or sent by certified mail.

(4) A written request for an administrative hearing shall be considered timely if received by the cabinet within:

(a) Ten (10) calendar days of:

1. An income withholding notice;

2. A notice of intent to boot a vehicle, in accordance with KRS 205.745(9); or

3. A notice of intent to request a credit report, in accordance with KRS 205.7685;

(b) Fifteen (15) calendar days of a notice of withholding from unemployment insurance, pursuant to KRS 341.392 and 341.420;

(c) Twenty (20) calendar days of:

1. An initial notice of monthly support obligation, in accordance with KRS 405.440(4);

2. An order to withhold assets, in accordance with KRS 405.490(4);

3. A request for denial or suspension of a license or certificate;

4. A lien notice, in accordance with KRS 205.745(6); or

5. A notice to place the obligor's name on the delinquent listing; or

(d) Thirty (30) calendar days of a:

1. Modified notice of monthly support obligation, in accordance with KRS 405.450(5);

2. Notice that an obligation amount was reviewed without change, in accordance with KRS 405.450(5); or

3. Notice regarding the collection of past-due support in accordance with KRS 154A.060(2)(g), 205.712(17), and 205.769.

(5) In accordance with KRS 205.712(13), an individual shall be granted an administrative hearing based upon a mistake in fact, such as an incorrect:

(a) Person identified as an obligor; or

(b) Current or past due support obligation.

(6) An appellant or authorized representative may withdraw an administrative hearing request by submitting a written request to the:

(a) Families and Children Administrative Hearings Branch, as specified in Section 3 of this administrative regulation; or

(b) Child support enforcement office that accepted the original request for an administrative hearing.

Section 3. Hearing Notification. (1) The Division of Administrative Hearings, Families and Children Administrative Hearings Branch shall acknowledge an administrative hearing request.

(2) A notice of an administrative hearing shall:

(a) Comply with the requirements of KRS 13B.050(3);

(b) Specify the name, address, and phone number of the person to notify if an appellant is unable to attend the scheduled hearing; and

(c) Specify that the hearing request shall be dismissed if an appellant or the authorized representative fails to appear for an administrative hearing without good cause as specified in Section 4(3) of this administrative regulation.

(3) Pursuant to KRS 405.450(1), the cabinet shall schedule an administrative hearing within sixty (60) calendar days of an individual's hearing request.

(4) An administrative hearing shall be conducted in accordance with KRS Chapter 13B[~~13B.080 and 13B.090~~].

(5) An individual that fails to appear for a scheduled hearing shall receive notification to provide good cause within ten (10) calendar days.

Section 4. Denial or Dismissal of an Administrative Hearing Request. (1) A hearing request shall be denied or dismissed if the:

(a) Request is not based on a mistake of fact as specified in

Section 2(5) of this administrative regulation;

(b) Request is untimely and good cause, as defined in subsection (3) of this section, is:

1. Not claimed; or

2. Found not to exist;

(c) Appellant submits a written request to withdraw the administrative hearing request; or

(d) Appellant or an authorized representative fails to appear for the scheduled hearing without:

1. Notifying the cabinet prior to the hearing; or

2. Establishing good cause for failure to appear, as defined in subsection (3) of this section.

(2) A claim of good cause for an untimely hearing request or failure to appear at an administrative hearing shall be established within ten (10) calendar days of receipt of a notice to provide good cause.

(3) Upon receipt of a good cause claim, a hearing officer shall determine if the appellant:

(a) Was away from home during the entire filing period;

(b) Is unable to read or comprehend the right to request an administrative hearing on the notice received;

(c) Moved, resulting in a delay in receiving or failure to receive the notice in the required time period;

(d) Was suffering from a serious illness;

(e) Was caring for an immediate household member who had a serious illness; or

(f) Was not at fault for the delay of the request, as determined by the hearing officer.

(4) The cabinet shall notify an appellant of the dismissal of an administrative hearing request by sending a recommended order of dismissal.

Section 5. Appellant's Rights. (1) An appellant or an appellant's legal representative shall have the right to examine and copy case material pertinent to the dispute before or during the hearing process in accordance with KRS 13B.090(3).

(2) The cabinet shall release case information as specified in subsection (1) of this section to the appellant's authorized representative if the appellant provides written authorization that is:

(a) Signed in the presence of child support enforcement staff who shall also sign as a witness; or

(b) Notarized.

(3) An appellant or representatives shall have the right to:

(a) Examine, prior to the hearing:

1. The list of witnesses to be called during the hearing;

2. Evidence to be presented at the hearing; and

3. Other information in the cabinet's possession that pertains to the hearing;

(b) Present witnesses or documents to support the appellant's claim; and

(c) Appeal the decision of the final order of the hearing to Circuit Court in accordance with KRS 13B.140.

Section 6. Obligation Pending a Hearing or Appeal. (1) If a hearing request is based on the dispute of:

(a) An initial notice of monthly support obligation, the obligation shall be stayed until a final order of the secretary[~~Commissioner of the Department for Income Support or designee~~] is issued, in accordance with KRS 405.450(2); or

(b) The findings of a modification review of an administratively established obligation, the amount of the existing obligation shall be:

1. Enforceable; and

2. Paid by the obligor pending receipt of the final order.

(2) If the action taken on behalf of the Child Support Enforcement Program is:

(a) Upheld, the obligation amount shall be retroactive to the effective date on the notice of monthly support obligation; or

(b) Found to be incorrect, the cabinet shall return to the obligor any overpayment made since the date the administrative hearing was requested.

(3) If an appellant files an appeal of the final order with the Circuit Court, the appellant shall be obligated to pay the amount listed on the notice of monthly support obligation while the appeal is pending.

Section 7. Recommended Order. (1) After the hearing has concluded, the hearing officer shall submit to the secretary of the Cabinet for Health and Family Services[~~draft~~] a recommended order in accordance with KRS 13B.110 that:

(a) Summarizes the facts of the case;

(b) Specifies the address where a party to the hearing may send an exception to the recommended order; and

(c) Identifies the:

1. Findings of fact;

2. Conclusions of law;

3. Supporting evidence; and

4. Applicable state and federal laws and administrative regulations.

(2)[~~In accordance with KRS 13B.110, the hearing officer shall issue the recommended order to the Commissioner of the Department for Income Support or designee within sixty (60) calendar days of the close of the hearing record.~~

~~(3)~~] A copy of the recommended order shall be sent to the:

(a) Appellant or representative;

(b) The secretary[~~Child support enforcement staff that attended the administrative hearing~~]; and

(c) Designated staff of the Child Support Enforcement's central office.

Section 8. Written Exceptions. [~~(1)~~] If a party to the hearing disagrees with the recommended order, within fifteen (15) days from the date the recommended order is mailed, the party may file with the secretary[~~a~~] written exceptions in accordance with KRS 13B.110(4)[~~exception with the Commissioner or designee.~~

~~(2) A written exception shall:~~

~~(a) Be filed in accordance with KRS 13B.110(4);~~

~~(b) Be based on facts and evidence presented at the hearing;~~

~~(c) Not refer to evidence that was not introduced at the hearing; and~~

~~(d) Be sent to the other parties that attended the administrative hearing~~].

Section 9. Final Order. (1) Within ninety (90) days from the date the recommended order is mailed, a final order shall be issued by the secretary[~~: (a)~~] in accordance with KRS 13B.120[~~;~~

~~(b) By the commissioner or designee on behalf of the cabinet; and~~

~~(c) Within ninety (90) calendar days of the recommended order, unless the recommended order is remanded in accordance with KRS 13B.120(4)~~].

(2) If the final order differs from the recommended order, the final order shall comply with KRS 13B.120(3).

Section 10. Incorporation by Reference. (1) "CS-180, Request for Administrative Hearing", 7/14[~~edition 4/09~~], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, Department for Income Support, Child Support Enforcement, 730 Schenkel Lane, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

STEVEN P. VENO, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: April 11, 2014

FILED WITH LRC: April 11, 2014 at 3 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 21, 2014, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky. Individuals interested in attending this hearing shall notify this agency in writing by May 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 close of business, June 2, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40621, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact person: Mary W. Sparrow

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation outlines how an individual that is aggrieved by an action or inaction of the Child Support Enforcement Program is afforded the opportunity for an administrative review of their case.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish procedures for a participant in a child support case to request an administrative hearing.

(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 hearing process outlined in Kentucky Revised Statute Chapter 13B.

(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 hearing process within the Child Support Enforcement Program and the Cabinet for Health and Family 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 Secretary of the Cabinet for Health and Family Services will receive a recommended order from the hearing officer, if an individual disagrees with the order, their exceptions are filed to the Secretary and the Secretary will issue the final order. Previously, the Commissioner of the Child Support Enforcement Program issued the final order.

(b) The necessity of the amendment to this administrative regulation: In order to achieve consistency within the Cabinet for Health and Family Services, in regards to the administrative hearing process. The Cabinet for Health and Family Services has taken a comprehensive review of its administrative hearing and complaint processes for various improvements, including timeliness, congruency with KRS Chapter 13B requirements, and objectivity. The amendment to this administrative regulation is necessary to align child support hearings with the reassignment of final order responsibilities from the Commissioner of the Department for Income Support to the Secretary of the Cabinet.

(c) How the amendment conforms to the content of the authorizing statutes: All administrative hearings and subsequent orders must conform to the authorizing statutes. The amendment conforms to the authorizing statutes by aligning the hearing process for child support enforcement participants with the reassignment of final order responsibilities in order to enhance the timeliness and objectivity in accordance with KRS Chapter 13B and federal law requirements.

(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 federal law requirements, enhancing the timeliness and objectivity of the final order.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals that are participants in the Kentucky Child Support Enforcement 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: Parties to an administrative hearing will direct exceptions to recommended orders to the Secretary of the Cabinet for Health and Family Services, rather than the Commissioner of the Department for Income Support.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). The regulated entities will incur no new or additional cost.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The amendment to this administrative regulation improves upon existing cabinet procedures and intends to ensure overall cabinet timeliness, objectivity, and compliance with KRS Chapter 13B.

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

(a) Initially: No additional funds will be necessary to implement the amendment to this administrative regulation.

(b) On a continuing basis: No additional funds will be necessary to implement the amendment to this administrative regulation. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds from The Child Support Enforcement State Program under Title IV-D of the Social Security Act support the implementation and enforcement of this administrative regulation. State General Funds are also utilized.

(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. The amendment to this administrative regulation does not require an increase in fees or funding.

(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. This administrative regulation does not establish any fees or directly or indirectly increase any fees.

(9) Tiering: Is tiering applied? Tiering is not applied, as this administrative regulation is applied in a like manner statewide.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 666 and 45 C.F.R. 303.35.

2. State compliance standards. KRS Chapter 13B.

3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 666 and 45 C.F.R. 303.35.

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

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This administrative regulation does not impose stricter, additional 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 Secretary's office of the Cabinet for Health and Family Services and the Child Support Enforcement program will be affected by the amendments to this administrative regulation.

2. Identify each state or federal regulation that requires or

authorizes the action taken by the administrative regulation. KRS Chapter 13B, KRS 205.712(2)(o), KRS 405.450, 45 C.F.R. 303.35 and 42 U.S.C. 666.

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

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

(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 funding.

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

(d) How much will it cost to administer this program for subsequent years? No additional funds will be necessary to implement this administrative regulation 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:

NEW ADMINISTRATIVE REGULATIONS

OFFICE OF KENTUCKY SECRETARY OF STATE
(New Administrative Regulation)

30 KAR 6:010. Kentucky address confidentiality program.

RELATES TO: KRS 14.300, 14.302, 14.304, 14.306, 14.310
STATUTORY AUTHORITY: KRS 14.304(2), (4), 14.306(3), (5), 14.318(2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 14.318(2) authorizes the Secretary of State to promulgate administrative regulations implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation implements KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

Section 1. Definitions. (1) "Address" is defined by KRS 14.300(1).
(2) "Applicant" is defined by KRS 14.300(2).
(3) "Filer" means a person who is:
(a) A:
1. Parent or guardian acting on behalf of a minor;
2. Guardian acting on behalf of a person who is declared incompetent; or
3. Designee of an applicant or a parent or guardian of a minor or a guardian of a person declared incompetent who cannot apply independently; and
(b) Applying to the Secretary of State to have an address designated by the Secretary of State serve for voting purposes as the address of the minor, incompetent person, or applicant.
(4) "Program Participant" is defined by KRS 14.300(5).

Section 2. Requirements for Application for Certification to Participate in the Address Confidentiality Program. (1) Application for certification to participate in the address confidentiality program shall be made to the Secretary of State by submitting a completed Application for Certification to Participate in Address Confidentiality Program.
(2) The Application for Certification to Participate in Address Confidentiality shall be:
(a) Notarized; and
(b) In English.

Section 3. Certification in the Address Confidentiality Program. (1) The Secretary of State shall approve an Application for Certification to Participate in Address Confidentiality Program and certify the applicant as a program participant if the applicant and the Application for Certification to Participate in Address Confidentiality Program meet the requirements established in KRS 14.304 and this administrative regulation.
(2) The Secretary of State shall notify the applicant or filer whether the Application for Certification to Participate in Address Confidentiality Program was denied or the applicant was certified as a program participant.
(a) If an Application for Certification to Participate in Address Confidentiality Program is denied, the Secretary of State shall inform the applicant or filer of the reason for the denial.
(b) If an applicant is certified as a program participant, the Secretary of State shall:
1. Assign to the program participant a participant number and designated address to be used for voting purposes; and
2. Issue to the program participant an Address Confidentiality Program Participant Card reflecting the participant number, designated address to be used for voting purposes, and date on which certification expires.
(3) If an applicant is certified as a program participant, participation in the address confidentiality program shall be effective as of the date of the notification of certification.

Section 4. Change of Program Participant's Name or Address.
(1) A program participant or a filer shall notify the Secretary of State of a change in the program participant's name or address by submitting to the Office of the Secretary of State a completed Address Confidentiality Program Participant Name or Address Change form.
(2) The Address Confidentiality Program Participant Name or Address Change form shall:
(a) Be in writing;
(b) Be in English;
(c) Be signed by the program participant or a filer;
(d) Include both the program participant's new information and information as certified; and
(e) Be considered filed on the day the Address Confidentiality Program Name or Address Change form is date-stamped received by the Office of the Secretary of State.

Section 5. Withdrawal from Participation in the Address Confidentiality Program. (1) A program participant or filer wishing to withdraw from participation in the address confidentiality program shall submit to the Secretary of State a Withdrawal from Participation in Address Confidentiality Program form.
(2) The Withdrawal from Participation in Address Confidentiality Program form shall be:
(a) In writing;
(b) In English;
(c) Signed by the program participant or a filer;
(d) Notarized or signed by a representative of any office designated pursuant to KRS 14.310 as a referring agency who assisted in the completion of the Withdrawal from Participation in Address Confidentiality Program form; and
(e) Submitted to the Secretary of State by mail or in person.

Section 6. Confirmation by the Secretary of State of a Withdrawal from Participation in the Address Confidentiality Program. (1) Upon receiving a Withdrawal from Participation in Address Confidentiality Program form, the Secretary of State shall mail to the program participant or filer a written confirmation of withdrawal.
(2) The written confirmation shall notify the program participant or filer:
(a) Of the date on which a Withdrawal from Participation in Address Confidentiality Program form was date stamped received by the Office of the Secretary of State; and
(b) That program participation shall be terminated ten (10) days following the date of the written confirmation of withdrawal, unless the program participant or a filer notifies the Secretary of State on or before that date that the withdrawal request was not legitimate because it was not voluntarily submitted by the program participant or a filer.

Section 7. Application for Renewal of Certification in the Address Confidentiality Program. (1) A program participant or filer wishing to renew certification in the address confidentiality program shall submit to the Secretary of State at least five (5) business days prior to the date on which the program participant's certification expires an Application for Certification to Participate in Address Confidentiality Program pursuant to Section 2 of this administrative regulation.
(2) The Application for Certification to Participate in Address Confidentiality Program shall be considered timely submitted for purposes of renewal if it is date-stamped received by the Office of the Secretary of State at least five (5) business days prior to the date on which the program participant's certification expires.

Section 8. Review by the Secretary of State of a Renewal Application for Certification to Participate in Address Confidentiality Program. (1) The Secretary of State shall approve a renewal Application for Certification to Participate in Address Confidentiality Program if the applicant and Application for Certification to Participate in Address Confidentiality Program meet the requirements established in KRS 14.304 and this administrative regulation.
(2) The Secretary of State shall notify the program participant or filer whether the renewal Application for Certification to

Participate in Address Confidentiality Program was denied or the program participant's certification was renewed within five (5) business days after it is date-stamped received by the Secretary of State.

(a) If a renewal Application for Certification to Participate in Address Confidentiality Program is denied, the Secretary of State shall inform the program participant or filer of the reason for denial.

(b) If a program participant's certification is renewed, the Secretary of State shall issue to the program participant a new Address Confidentiality Program Participant Card pursuant to Section 3(2)(b)2 of this administrative regulation, and the renewal shall be effective as of the date of the notification of renewal.

Section 9. Appeal from Cancellation of Certification in Address Confidentiality Program. (1) A program participant or filer wishing to appeal from a cancellation of certification in the address confidentiality program shall submit to the State Board of Elections an Appeal from Cancellation of Certification in Address Confidentiality Program form.

(2) The Appeal from Cancellation of Certification in Address Confidentiality Program shall be considered timely submitted if it is date-stamped received by the State Board of Elections within thirty (30) days of the date of the notice of certification cancellation.

(3) The Appeal from Cancellation of Certification in Address Confidentiality Program shall:

(a) Be in writing;

(b) Be in English;

(c) Be signed by the program participant or filer; and

(d) Include information as to why certification in the address confidentiality program should not be cancelled.

(4) If an Appeal from Cancellation of Certification in Address Confidentiality Program is not timely submitted, cancellation of certification in the address confidentiality program shall be effective upon the expiration of thirty (30) days after the date of the notice of certification cancellation.

Section 10. Review by the Executive Director of the State Board of Elections of an Appeal from Cancellation of Certification in Address Confidentiality Program. (1) The executive director of the State Board of Elections shall approve or deny an Appeal from Cancellation of Certification in Address Confidentiality Program within five (5) business days after it is date-stamped received by the State Board of Elections.

(a) The executive director of the State Board of Elections shall approve an Appeal from Cancellation of Certification in Address Confidentiality Program if the executive director determines that grounds for cancellation pursuant to KRS 14.306 do not exist.

(b) The executive director of the State Board of Elections shall deny an Appeal from Cancellation of Certification in Address Confidentiality Program if the executive director determines that grounds for cancellation pursuant to KRS 14.306 exist.

(2) The executive director of the State Board of Elections shall provide to the program participant or filer written notice of the decision regarding an Appeal from Cancellation of Certification in Address Confidentiality Program.

(3) If an Appeal from Cancellation of Certification in Address Confidentiality Program is timely submitted and denied pursuant to this section, cancellation of certification in the address confidentiality program shall be effective on the date on which the notice of denial is mailed.

(4) The decision of the executive director of the State Board of Elections shall conclude the appeal procedures pursuant to KRS Chapter 14 and this administrative regulation.

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

(a) "Application for Certification to Participate in Address Confidentiality Program," March 2014;

(b) "Address Confidentiality Program Participant Card," March 2014;

(c) "Address Confidentiality Program Participant Name or Address Change," March 2014;

(d) "Withdrawal from Participation in Address Confidentiality Program," March 2014; and

(e) "Appeal from Cancellation of Certification in Address Confidentiality Program," March 2014.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Secretary of State's Office, 700 Capital Avenue, State Capitol, Suite 152, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m., or may be obtained at http://www.sos.ky.gov.

ALISON LUNDERGAN GRIMES, Secretary of State

APPROVED BY AGENCY: March 24, 2014

FILED WITH LRC: March 24, 2014 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 28, 2014, at 1:00 p.m., Eastern Time, at the State Board of Elections, 140 Walnut Street, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by five (5) work days prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made available unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted until close of business, June 2, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Lindsay Hughes Thurston, Assistant Secretary of State, 700 Capital Ave., Ste. 152, Frankfort, Kentucky 40601, phone (502) 564-3490, fax (502) 564-5687.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Lindsay Hughes Thurston

(1) Provide a brief narrative summary of:

(a) What this administrative regulation does: KRS 14.318 authorizes the Secretary of State to promulgate administrative regulations implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation implements KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to implement KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 14.318 authorizes the Secretary of State to promulgate administrative regulations implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation implements KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

(d) How this administrative regulation will assist in the effective administration of the statutes: KRS 14.318 authorizes the Secretary of State to promulgate administrative regulations implementing KRS 14.300 to 14.310, 14.314, and 14.316. This administrative regulation assists in the effective administration of the statutes by implementing KRS 14.300, 14.302, 14.304, 14.306, and 14.310.

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

(a) How the amendment will change the existing administrative regulation: This 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 an unknown number of victims of specified crimes who wish to

keep confidential their addresses, address confidentiality program participants, the Office of the Secretary of State, the State Board of Elections, and referring agencies designated under KRS 14.310.

(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: Victims of specified crimes are not required to take any action to comply with this administrative regulation but will have the opportunity to have their addresses kept out of publicly available voter records and vote via mail-in absentee ballot by following the procedures set forth in this administrative regulation. Program participants will be required to follow the procedures established in this administrative regulation for notifying the Office of the Secretary of State of a change of name or address, withdrawing from the address confidentiality program, renewing certification to participate in the address confidentiality program, and appealing a cancellation of certification to participate in the address confidentiality program. In order to comply with this administrative regulation, the Office of the Secretary of State, State Board of Elections, and referring agencies designated under KRS 14.310 will need to familiarize themselves with the procedures and forms set forth in this administrative regulation. The Office of the Secretary of State and State Board of Elections will also be required to process forms submitted by applicants, filers, and program participants 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 victims of specified crimes, program participants, or referring agencies designated under KRS 14.310 to comply with this administrative regulation. The cost, if any, to the Office of the Secretary of State and State Board of Elections to comply with this administrative regulation will be de minimis.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Voting records, including voters' names and addresses, are matters of public record. In some instances, victims of specified crimes who are otherwise eligible to register to vote and vote do not do so because they fear the perpetrators of the crimes against them would be able to determine their addresses or voting precincts, compromising their safety or the safety of their children. As a result of compliance with this administrative regulation, victims of specified crimes will be able to have their addresses kept out of publicly available voter records and vote via mail-in absentee ballot so that they can register to vote and vote without their addresses or voting precincts being discovered. The Office of the Secretary of State and State Board of Elections have an interest in ensuring that all eligible Kentuckians are able to exercise the right to vote, and compliance with this administrative regulation furthers that interest by enabling victims of specified crimes to register to vote and vote without fear that the perpetrators of the crimes against them will be able to determine their addresses or voting precincts. Referring agencies designated under KRS 14.310 will benefit from the extension and enhancement of their efforts to ensure the safety of victims of specified crimes.

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

(a) Initially: Ordinary printing and personnel costs already anticipated in budget.

(b) On a continuing basis: Ordinary printing and personnel costs already anticipated in budget.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Secretary of State and/or State Board of Elections' budget.

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

(9) TIERING: Is tiering applied? Tiering was not applied because this administrative regulation applies equally to all individuals affected.

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 Office of the Secretary of State and State Board of Elections.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation: This administrative regulation is authorized by KRS 14.318(2), 14.304(1), 14.304(4), 14.306(3), and 14.306(5).

(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 additional revenue for state or local governments during the first year.

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

(c) How much will it cost to administer this program for the first year? The cost, if any, to state and local governments to administer this program for the first year will be de minimis.

(d) How much will it cost to administer this program for subsequent years? The cost, if any, to state and local governments to administer this program for subsequent years will be de minimis.

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

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

GENERAL GOVERNMENT CABINET
Kentucky Board of Medical Licensure
(Repealer)

201 KAR 9:301. Repeal of 201 KAR 9:300.

RELATES TO: KRS 311.900 – 311.928
STATUTORY AUTHORITY: KRS 311.901(1)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 311.901(1) requires the Kentucky Board of Medical Licensure to promulgate administrative regulations relating to the licensure and practice of athletic trainers. This administrative regulation acts specifically to repeal 201 KAR 9:300, Athletic trainer restrictions, which is adequately addressed by KRS 311.900(1) and (3).

Section 1. 201 KAR 9:300, Athletic trainer restrictions, is hereby repealed.

PRESTON P. NUNNELLEY, M.D., President
APPROVED BY AGENCY: March 31, 2014
FILED WITH LRC: April 9, 2014 at 11 a.m.
PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 28, 2014 at 10:00 a.m. at the offices of the Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville,

Kentucky 40222. Individuals interested in being heard at this hearing shall notify this agency in writing by May 20, 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 the close of business on June 2, 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: Leanne K. Diakov, General Counsel, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222, phone (502) 429-7150, fax (502) 429-7118.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Leanne K. Diakov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation repeals 201 KAR 9:300, Athletic trainer restrictions.

(b) The necessity of this administrative regulation: It is necessary to promulgate this regulation to repeal 201 KAR 9:300, Athletic trainer restrictions, because it is already addressed by KRS 311.900.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation acts specifically to repeal 201 KAR 9:300, Athletic trainer restrictions, because it is already addressed in KRS 311.900.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation acts specifically to repeal 201 KAR 9:300, Athletic trainer restrictions, because it is already addressed in KRS 311.900.

(2) If this is an amendment to an existing 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 amendment will affect all athletic trainers licensed in the Commonwealth of Kentucky.

(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 this administrative regulation or amendment: No required action on the part of athletic trainers.

(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): None.

(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 funding to be used for the implementation and enforcement of this administration regulation: None

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

(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 appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals 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 Kentucky Board of Medical Licensure 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 311.901(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. 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? None

(d) How much will it cost to administer this program for subsequent years? None

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

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

GENERAL GOVERNMENT CABINET
Kentucky Applied Behavior Analysis Licensing Board
(New Administrative Regulation)

201 KAR 43:100. Telehealth and Telepractice.

RELATES TO: KRS 319C.140(2)

STATUTORY AUTHORITY: KRS 319C.140(2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 319C.140(2) requires the board to promulgate administrative regulations related to utilization of telehealth as a means of healthcare delivery.

Section 1. Requirements for Licensees Providing Applied Behavior Analytic Services via Telehealth. (1) A licensee who provides applied behavior analytic services via telehealth shall:

(a) Maintain competence with the technologies utilized, including but not limited to understanding and adequately addressing the actual and potential impact of those technologies on clients, supervisees, or other professionals;

(b) Maintain compliance with KRS Chapter 319C, 201 KAR Chapter 43, and all other applicable federal, state, and local laws;

(c) At the onset of the delivery of care via telehealth, identify appropriate emergency response contacts local to the client such that those contacts are readily accessible in the event of an emergency;

(d) Protect and maintain the confidentiality of data and information in accordance with all applicable federal, state, and

local laws including but not limited to HIPAA; and

(e) Dispose of data and information only in accordance with federal, state, and local law and in a manner that protects the data and information from unauthorized access.

(2) Applied behavior analysis with a client shall not commence via telehealth. An initial, in-person meeting for the licensee and client who prospectively utilize telehealth shall occur. The licensee shall, at the initial, in-person meeting with the client:

(a) Make reasonable attempts to verify the identity of the client;

(b) Obtain alternative means of contacting the client other than electronically;

(c) Provide to the client alternative means of contacting the licensee other than electronically;

(d) Document if the client has the necessary knowledge and skills to benefit from the type of telehealth to be provided by the licensee; and

(e) Inform the client in writing about and obtain the client's informed written consent regarding:

1. The limitations of using technology in the provision of applied behavior analytic services;

2. Potential risks to confidentiality of information due to technology in the provision of applied behavior analytic services;

3. Potential risks of disruption in the use of telehealth technology;

4. When and how the licensee will respond to routine electronic messages;

5. In what circumstances the licensee will use alternative communications for emergency purposes;

6. Who else may have access to client communications with the licensee;

7. How communications can be directed to a specific licensee;

8. How the licensee stores electronic communications from the client; and

9. That the licensee may elect to discontinue the provision of services through telehealth at any time.

Section 2. Jurisdictional Considerations. (1) A person providing applied behavior analytic services via telehealth to a person physically located in Kentucky at the time the services are provided shall be licensed by the board.

(2) A person providing applied behavior analytic services via telehealth from a physical location in Kentucky shall be licensed by the board. This person may be subject to licensure requirements in other states where the services are received by the client.

Section 3. Representation of Services and Code of Conduct. A licensee using telehealth to deliver services:

(1) Shall not engage in false, misleading, or deceptive advertising; and

(2) Shall not split fees.

SHELLI DESKINS, Chair

APPROVED BY AGENCY: March 28, 2014

FILED WITH LRC: April 1, 2014 at 2 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall be held on May 23, 2014 at 9:00 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 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 June 2, 2014 at the close of business. 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: Lindsey Lane, Board Administrator, Kentucky Applied Behavior Analyst Licensing Board, PO Box 1370, Frankfort, Kentucky 40602, phone (502) 564-3296, fax (502) 696-4961.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Michael West

(1) Provide a brief summary of:

(a) What this administrative regulation does: This regulation provides guidelines for the provision of services via telehealth.

(b) The necessity of this administrative regulation: This regulation is necessary to implement the provisions of KRS 319C.140(2).

(c) How this administrative regulation conforms to the content of the authorizing statutes: The regulation is in conformity as the authorizing statute which authorizes and requires the board to promulgate regulations related to telehealth.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation will assist the board and the public by providing detailed guidelines regarding the use of telehealth as a means of delivery for 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: NA

(b) The necessity of the amendment to this administrative regulation: NA

(c) How the amendment conforms to the content of the authorizing statutes: NA

(d) How the amendment will assist in the effective administration of the statutes: NA

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: Approximately fifty (50) individuals are licensed by the board.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Licensees providing services via telehealth will be required to act in accordance with this regulation.

(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 licensee will be able to provide service flexibility through providing services remotely.

(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 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 new 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: 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 because it does not discriminate between licensees based on any identifiable factor.

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 Applied

Behavior Analysis Licensing Board.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 319C.060(2)(a). KRS 319C.140(2).

(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:

EDUCATION AND WORKFORCE DEVELOPMENT CABINET
Kentucky Board of Education
Department of Education
(New Administrative Regulation)

704 KAR 3:370. Professional Growth and Effectiveness System.

RELATES TO: KRS 156.557

STATUTORY AUTHORITY: KRS 156.070, 156.557(5)(c)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 156.557(2) and (5)(c) require the Kentucky Board of Education to promulgate administrative regulations to establish a statewide professional growth and effectiveness system for the purposes of supporting and improving the performance of all certified school personnel and to develop written guidelines for local school districts to follow in implementing a statewide system of evaluation for certified school personnel. This administrative regulation establishes a statewide professional growth and effectiveness system to support and improve the performance of all certified school personnel.

Section 1. Definitions. (1) "Artifact" means a product of a certified school personnel's work that demonstrates knowledge and skills.

(2) "Assistant principal" means a certified school personnel who devotes the majority of employed time in the role of assistant principal, for which administrative certification is required by the Education Professional Standards Board pursuant to Title 16 KAR.

(3) "Certified administrator" means a certified school personnel, other than principal or assistant principal, who devotes the majority of employed time in a position for which administrative certification is required by the Education Professional Standards Board pursuant to Title 16 KAR.

(4) "Certified school personnel" means a certified employee, below the level of superintendent, who devotes the majority of employed time in a position in a district for which certification is required by the Education Professional Standards Board pursuant to Title 16 KAR and includes certified administrators, assistant principals, principals, other professionals, and teachers.

(5) "Conference" means a meeting between the evaluator and the evaluatee for the purposes of providing evaluator feedback, analyzing the results of an observation or observations, reviewing other evidence to determine the evaluatee's accomplishments and areas for growth, and leading to the establishment or revision of a professional growth plan.

(6) "Evaluatee" means the certified school personnel who is being evaluated.

(7) "Evaluator" means the primary evaluator as described in KRS 156.557(5)(c)2.

(8) "Formative evaluation" is defined in KRS 156.557(1)(a).

(9) "Job category" means a group or class of certified school personnel positions with closely related functions.

(10) "Local contribution" means a rating based on the degree to which a teacher, principal, or assistant principal meets student growth goals and is used for the student growth measure.

(11) "Local formative growth measures" is defined in KRS 156.557(1)(b).

(12) "Observation" means a data collection process conducted by a certified observer for the purpose of evaluation and may include notes and professional judgments made during one (1) or more classroom or worksite visits of any duration, may include examination of artifacts, and may be conducted in person or through video.

(13) "Observer certification" means a process of training and ensuring that certified school personnel who serve as observers of evaluatees have demonstrated proficiency in rating teachers for the purposes of evaluation and feedback.

(14) "Observer recalibration" means the process of ensuring that certified school personnel have maintained proficiency and accuracy in observing teachers for the purposes of evaluation and providing feedback.

(15) "Other professionals" means certified school personnel and does not include teachers, administrators, assistant principals, or principals.

(16) "Overall growth rating" means the rating that is calculated for a teacher evaluatee pursuant to the requirements of Sections 8(5) and (6) of this administrative regulation and that is calculated for an assistant principal or principal evaluatee pursuant to the requirements of Sections 11(4) and (5) of this administrative regulation.

(17) "Peer assistance and review process" means a process created to provide peer assistance and review for the purposes of supporting and improving instructional practice and making personnel decision recommendations.

(18) "Peer observation" means observation and documentation by trained certified school personnel.

(19) "Performance criteria" means the areas, skills, or outcomes on which certified school personnel shall be evaluated.

(20) "Performance rating" means the summative description of a teacher, principal, or assistant principal evaluatee's performance and includes the following ratings:

(a) "Exemplary" means the rating for performance that consistently exceeds expectations for effective performance;

(b) "Accomplished" means the rating for performance that consistently meets expectations for effective performance;

(c) "Developing" means the rating for performance that inconsistently meets expectations for effective performance; and

(d) "Ineffective" means the rating for performance that consistently fails to meet expectations for effective performance.

(21) "Preschool teacher" means a certified school personnel who holds a certificate required by 16 KAR 2:040 and who meets the preschool lead teacher qualifications required by 704 KAR 3:410, Section 7.

(22) "Principal" means a certified school personnel who devotes the majority of employed time in the role of principal, for which administrative certification is required by the Education Professional Standards Board pursuant to 16 KAR 3:050.

(23) "Professional growth and effectiveness system" or "system" means an evaluation system to support and improve the performance of certified school personnel that meets the requirements of KRS 156.557(1)(c), (2), and (3) and that uses clear and timely feedback to guide professional development.

(24) "Professional growth plan" means an individualized plan for a certified personnel that is focused on improving professional practice and leadership skills, aligned with performance standards

and the specific goals and objectives of the school improvement plan or the district improvement plan, built using a variety of sources and types of data that reflect student needs and strengths, evaluatee data, and school and district data, produced in consultation with the evaluator, and includes:

(a) Goals for enrichment and development that are established by the evaluatee in consultation with the evaluator;

(b) Objectives or targets aligned to the goals;

(c) An action plan for achieving the objectives or targets and a plan for monitoring progress;

(d) A method for evaluating success; and

(e) The identification, prioritization, and coordination of presently available school and district resources to accomplish the goals.

(25) "Professional practice" means the demonstration, in the school environment, of the evaluatee's professional knowledge and skill.

(26) "Professional practice rating" means the rating that is calculated for a teacher evaluatee pursuant to Sections 8(2), (3), and (4) of this administrative regulation and that is calculated for a principal or assistant principal evaluatee pursuant to the requirements of Section 10(2) of this administrative regulation.

(27) "Self-reflection" means the annual process by which certified school personnel assess the effectiveness and adequacy of their knowledge and performance for the purpose of identifying areas for professional learning and growth.

(28) "Sources of evidence" means the multiple measures listed in KRS 156.557(4) and in Sections 8 and 10 of this administrative regulation.

(29) "State contribution" means the student growth percentiles, as defined in 703 KAR 5:200, Section 1(11), for teachers and the next generation learners goal for principals and assistant principals.

(30) "Student growth" is defined in KRS 156.557(1)(c).

(31) "Student growth goal" means a goal focused on learning, that is specific, appropriate, realistic, and time-bound, that is developed collaboratively and agreed upon by the evaluatee and evaluator, and that uses local formative growth measures.

(32) "Student growth percentile" is defined in 703 KAR 5:200, Section 1(11).

(33) "Student voice survey" means the department-approved student perception survey that is administered annually to a minimum of one (1) district-designated group of students per teacher evaluatee and provides data on specific aspects of the classroom experience and professional practice of the teacher evaluatee.

(34) "Summative evaluation" is defined by KRS 156.557(1)(d).

(35) "Teacher" means a certified school personnel who has been assigned the lead responsibility for student learning in a classroom, grade level, subject, or course and holds a teaching certificate under 16 KAR 2:010 or 16 KAR 2:020.

(36) "Working conditions survey goal" means a school improvement goal set by a principal or assistant principal every two (2) years with the use of data from the department-approved working conditions survey.

Section 2. Implementation Timeline. (1) During the 2014-2015 school year, all local districts shall fully implement the requirements of KRS 156.557 and this administrative regulation for all certified school personnel except other professionals, preschool teachers, and teachers of career and technical education in area technology centers, and may, if the system plan is approved by the local board of education, use the results from the system to inform personnel decisions. The use of a district's present evaluation plan, in addition to the system, during the 2014-2015 school year, will comply with this administrative regulation. During the 2014-2015 school year, the overall school and district accountability scores described in 703 KAR 5:225 shall not include the results from the system.

(2) During the 2014-2015 school year, all school districts shall pilot the system for other professionals and preschool teachers. During the 2014-2015 school year, school districts shall evaluate preschool teachers and other professionals pursuant to the requirements of Section 13 of this administrative regulation. Beginning in the 2015-2016 school year, all school districts shall fully implement the system for other professionals and preschool teachers.

(3) Beginning in the 2015-2016 school year, all school districts shall fully implement the system for all certified school personnel, use the system to inform personnel decisions for all certified school personnel, and the overall school and district accountability scores described in 703 KAR 5:225 shall include the results from the system.

Section 3. Approval of Local Professional Growth and Effectiveness System Plan and Procedures. (1) Each local school district shall submit to the department a professional growth and effectiveness system plan and procedures to establish the district's evaluation system for all certified school personnel.

(2) The department shall approve each local school district's plan and procedures that comply with the requirements established in KRS 156.557 and this administrative regulation.

Section 4. Local Professional Growth and Effectiveness Policies. The local board of education shall establish a written policy for implementing the system for all certified school personnel in the district, consistent with the requirements of KRS 156.557 and this administrative regulation. The local board of education shall develop, adopt, and submit to the department for approval a policy for evaluation of the district superintendent, consistent with the requirements of KRS 156.557(6) and this administrative regulation.

Section 5. Local Evaluation Procedures and Forms. (1) A local evaluation committee shall develop, and the local board of education shall act upon, system procedures and forms for the evaluation of certified school personnel positions.

(2) The local board of education shall adopt procedures and forms that meet the requirements of KRS 156.557(5)(c) and include the requirements established in this subsection.

(a) The district may require the utilization of additional trained administrative personnel to observe and provide information to the evaluator.

(b) The district shall require a minimum of one (1) peer observation of a teacher evaluatee during the summative evaluation year, documentation of peer observations in the department-approved technology platform, and sharing the documentation with the teacher for formative evaluation purposes. At the request of a teacher, peer observations may be used in the formative process.

(c) Beyond the minimum observation requirements set forth in KRS 156.557 and this administrative regulation, the district may establish uniform requirements for the length, frequency, and nature of observations conducted by an evaluator for the purpose of evaluation.

(d) The district shall require a teacher evaluator to conduct a minimum of three (3) observations of a teacher evaluatee during the summative evaluation cycle and, at a minimum, one (1) full classroom observation during the summative year and to document all observations in the department-approved technology platform.

(e) The district shall require a principal evaluator to conduct a minimum of two (2) site visits each year.

(f) The district shall create a process for selection of peer observers.

(g) The district shall require a formative evaluation conference between the evaluator and the evaluatee within five (5) working days following each observation by the evaluator.

(h) The district shall require the summative evaluation conference be held at the end of the summative evaluation cycle and include all applicable system data.

(i) The district shall require summative evaluation, with multiple observations, to occur annually for each teacher who has not attained continuing service status under KRS 161.740 or continuing status under KRS 156.800(7) and may utilize the formative data collected during the beginning teacher internship

period, pursuant to 16 KAR 7:010, in the summative evaluation of an intern teacher.

(j) The district shall require multiple observations of a certified school personnel who has attained continuing service status under KRS 161.740 or continuing status under KRS 156.800(7) and whose observation results are determined to be ineffective.

(k) The district shall require summative evaluation at least once every three (3) years for a teacher who has attained continuing service status under KRS 161.740 or continuing status under KRS 156.800(7).

(l) The district, upon the request of a teacher, may use peer observation data in the formative process.

(m) The district shall require summative evaluation annually for a certified administrator, assistant principal, or principal.

(n) The district shall require a summative evaluation of a certified school personnel be documented in writing and be included in the evaluatee's official personnel record.

(o) The district shall require documentation of a summative evaluation of a teacher, principal, and assistant principal in the department-approved technology platform.

(p) The district shall require inclusion of the overall performance rating sources of evidence in the documentation of a certified school personnel's summative evaluation.

(q) The district shall provide an opportunity for a written response by the evaluatee, and require the response be included in the official personnel record.

(r) The district may develop and implement a peer assistance and review process.

(3) The local board of education shall develop, adopt, and submit to the department for approval procedures for evaluation of the district superintendent, consistent with the requirements of KRS 156.557(6) and this administrative regulation.

Section 6. Training and Testing of Evaluators and Observers. (1) The district shall include evaluation and observation training in the district's system plan and procedures submitted to the department for approval pursuant to Section 3 of this administrative regulation.

(2) The district shall ensure an evaluator meets the requirements of the district's system plan and procedures prior to evaluating a certified school personnel.

(3) An evaluator shall be trained and tested and approved on a four (4) year cycle.

(4) Year one (1) of the district's evaluator training cycle shall include the following training requirements:

(a) Training on all statutes and administrative regulations applicable to the evaluation of certified school personnel;

(b) Training in identifying effective teaching and management practices, in effective observation and conferencing techniques, in development of student growth goals, in providing clear and timely feedback, in establishing and assisting with a professional growth plan, and in summative decision techniques;

(c) Training provided by the department for all certified administrator evaluators who have never evaluated certified school personnel. Other certified administrators who have not received training in the skill areas listed in paragraph (b) of this subsection may also be trained by the department; and

(d) Training, for all other evaluators, by a provider who has been approved by the department as a trainer for the Instructional Leadership Improvement Program established in 704 KAR 3:325.

(5) Year one (1) of the district's evaluator training cycle shall include the testing requirements established in this subsection.

(a) An evaluator shall successfully complete testing of research-based and professionally accepted teaching and management practices and effective evaluation techniques.

(b) The testing shall be conducted by the department or an individual or agency approved by the department.

(c) The testing shall include certification as an observer through the department-approved observer certification process for an evaluator who is observing teachers for the purpose of evaluation.

(6) The department shall issue year one (1) approval as an evaluator upon the evaluator's successful completion of the required evaluation training and testing program and successful completion of observer certification.

(7) Years two (2) and three (3) of the district's evaluator training and testing cycle shall include in each year:

(a) Observer recalibration training, in the department-approved technology platform, for all evaluators who observe teachers for the purpose of evaluation; and

(b) A minimum of six (6) hours of evaluation training on any changes to the district's system plan, policies, or procedures, or to statutes or administrative regulations related to the evaluation of certified school personnel.

(8) Year four (4) of the district's evaluator training and testing cycle shall include refresher evaluator training and, if evaluating teachers, refresher observer certification training and testing.

(9) The district shall require peer observers to complete the department-developed peer observer training at least once every three (3) years.

(10) The district shall designate a contact person responsible for monitoring evaluator training and for implementing the system.

Section 7. Professional Practice Rating and Student Growth Rating for Teachers. (1) The district's professional practice rating form shall utilize The Framework for Teaching Evaluation Instrument, 2011 Edition, in conjunction with the Teacher Evaluation Crosswalk, in compliance with KRS 156.557 and the requirements of this administrative regulation and shall include the following:

(a) Planning and Preparation Domain. Components shall include: Knowledge of Content and Pedagogy, Demonstrating Knowledge of Students, Setting Instructional Outcomes, Demonstrating Knowledge of Resources, Designing Coherent Instruction, and Designing Student Assessments;

(b) Classroom Environment Domain. Components shall include: Creating an Environment of Respect and Rapport, Establishing a Culture of Learning, Managing Classroom Procedures, Managing Student Behavior, and Organizing Physical Space;

(c) Instruction Domain. Components shall include: Communicating with Students, Questioning and Discussion Techniques, Engaging Students in Learning, Using Assessment in Instruction, and Demonstrating Flexibility and Responsiveness; and

(d) Professional Responsibilities Domain. Components shall include: Reflecting on Teaching, Maintaining Accurate Records, Communicating with Families, Participating in a Professional Community, Growing and Developing Professionally, and Showing Professionalism.

(2) The district's professional practice rating evaluation form shall list, in each component, the performance criteria that characterize effective teaching and apply to the teacher evaluatee.

(3) The district shall explain and discuss the professional practice rating domains, components, and performance criteria, and the evaluation process with a teacher evaluatee no later than the end of the evaluatee's first thirty (30) calendar days of reporting for employment each school year. Amendments to local systems of teacher evaluation approved by the department after the end of the teacher's first thirty (30) calendar days of the school year shall not apply to the teacher until the following school year.

(4) A professional practice rating evaluation form shall be specific to the teacher's job category.

(5) The evaluator shall utilize The Framework for Teaching Evaluation Instrument, 2011 Edition, in conjunction with the Teacher Evaluation Crosswalk, in compliance with KRS 156.557 and the requirements of this administrative regulation, to determine ratings for the teacher on each of the four (4) domains.

(6) The evaluator shall use evidence from professional growth plans and self-reflection, observation, and student voice surveys, in combination with professional judgment, to inform the teacher's rating on each of the four (4) domains listed in subsection (1) of this section.

(7) The evaluator may, if included in the district's approved evaluation plan, use additional district-determined sources of evidence to inform the teacher's professional practice rating.

(8) The evaluator shall utilize the following decision rules for determining the professional practice rating for a teacher:

(a) If a teacher is rated ineffective in the classroom environment domain or in the instruction domain, the teacher's professional practice rating shall be not be exemplary or accomplished;

(b) If a teacher is rated ineffective in the classroom environment domain and in the instruction domain, the teacher's professional practice rating shall be ineffective;

(c) If a teacher is rated ineffective in any domain, the teacher's professional practice rating shall be accomplished, developing, or ineffective;

(d) If a teacher is rated developing in two (2) domains and accomplished in two (2) domains, the teacher's professional practice rating shall be accomplished;

(e) If a teacher is rated developing in two (2) domains and exemplary in two (2) domains, the teacher's professional practice rating shall be accomplished; and

(f) If a teacher is rated accomplished in two (2) domains and exemplary in two (2) domains, the teacher's professional practice rating shall be exemplary.

(9) The district shall determine the teacher's overall student growth rating as established in this subsection.

(a) The student growth measure shall consist of a state contribution, when available, and a local contribution.

(b) The Kentucky Board of Education shall determine the scale for low, expected, and high growth regarding the state contribution and the department shall provide the scale to local school districts.

(c) Student growth goals shall be determined as established in this paragraph.

1. The teacher shall develop and implement a minimum of one (1) student growth goal each year.

2. Because individualized education plan (IEP) goals are student-specific, IEP goals may inform, but shall not be used as, student growth goals.

3. The district shall ensure that student growth goals and measures of student growth are rigorous and comparable across schools in the local school district.

(d) The local school district shall determine the scale for low, expected, and high student growth goal ratings. In determining the scale, local school districts shall consider the definition of typical student growth contained in 703 KAR 5:200, Section 1(12).

(10) The local school district shall develop a process for using professional judgment and the following sources of evidence to determine the overall student growth rating:

(a) Growth trends consisting of the three (3) most recent years of student growth percentile data, as defined in 703 KAR 5:200, Section 1(9), when available, for teachers; and

(b) Growth trends consisting of the three (3) most recent years of student growth goal data, when available, for all teachers.

Section 8. Overall Performance Category of Teachers. (1) The overall performance category for teachers shall be determined by combining the teacher's professional practice rating and the teacher's overall student growth rating, as illustrated by the Kentucky Professional Growth and Effectiveness System Model for Summative Evaluation of Teachers.

(2) The district shall determine the teacher's overall performance category with the decision rules established in this subsection.

(a) A teacher's overall performance rating shall be exemplary if:

1. The professional practice rating is exemplary and the overall student growth rating is high;

2. The professional practice rating is exemplary and the overall student growth rating is expected; or

3. The professional practice rating is accomplished and the overall student growth rating is high.

(b) A teacher's overall performance rating shall be accomplished if:

1. The professional practice rating is exemplary and the overall student growth rating is low;

2. The professional practice rating is accomplished and the overall student growth rating is expected; or

3. The professional practice rating is developing and the overall student growth rating is high;

(c) A teacher's overall performance category shall be developing if:

1. The professional practice rating is accomplished and the overall student growth rating is low;

2. The professional practice rating is developing and the overall student growth rating is expected;

3. The professional practice rating is developing and the overall student growth rating is low; or

4. The professional practice rating is ineffective and the overall student growth rating is high.

(d) A teacher's overall performance category shall be ineffective if:

1. The professional practice rating is ineffective and the overall student growth rating is expected; or

2. The professional practice rating is ineffective and the overall student growth rating is low.

Section 9. Professional Growth Plan and Cycle for Teachers. A teacher shall be placed on an appropriate growth plan and summative evaluation cycle based on the professional practice rating and the overall student growth rating, as illustrated by the Kentucky Professional Growth Plan Model for Teachers.

(1) A teacher whose professional practice rating is exemplary or accomplished and who has an expected or high overall student growth rating shall have a professional growth plan that includes: goals set by the teacher, with evaluator input; activities that are teacher-directed and implemented with colleagues; a formative review annually; and a summative evaluation that occurs at the end of year three (3) of the evaluation cycle.

(2) A teacher whose professional practice rating is accomplished or exemplary, with a low overall student growth rating, or developing, with a high overall student growth rating, shall have a professional growth plan that includes: goals set by the teacher with evaluator input; if there is a low student growth rating, one (1) goal shall focus on low student growth outcome; an annual formative review; and a summative evaluation that occurs at the end of year three (3) of the evaluation cycle.

(3) A teacher whose professional practice rating is developing, with an expected overall student growth rating, shall have a professional growth plan that includes: goals set by the teacher with evaluator input; one (1) goal that addresses professional practice or student growth; activities that are teacher-directed and implemented with colleagues; an annual formative review; and a summative evaluation that occurs at the end of year three (3) of the evaluation cycle.

(4) A teacher whose professional practice rating is developing, with a low overall student growth rating, or whose professional practice rating is ineffective, with an expected or high overall student growth rating, shall have a professional growth plan that includes goals determined by the evaluator: goals shall focus on professional practice and student growth, include an annual formative review, and include a summative evaluation that occurs at the end of one (1) year.

(5) A teacher whose professional practice rating is ineffective, with a low overall student growth rating, shall have an improvement plan with goals determined by the evaluator: the goals shall focus on low performance areas and a summative evaluation shall occur at the end of the plan, whose duration is determined by the evaluator and may last up to one (1) year.

Section 10. Professional Practice Rating and Overall Student Growth Rating for Principals and Assistant Principals. (1) The district's professional practice rating form shall utilize the Principal and Assistant Principal Performance Standards and the Principal and Assistant Principal Performance Standards Crosswalk, in compliance with KRS 156.557 and the requirements of this administrative regulation, and shall include the performance standards and descriptors established in this subsection.

(a) Instructional Leadership Performance Standard. The evaluatee fosters the success of all students by facilitating the

development, communication, implementation, and evaluation of a shared vision of teaching and learning that leads to student academic growth and school improvement.

(b) School Climate Performance Standard. The evaluatee fosters the success of all students by developing, advocating, and sustaining an academically rigorous, positive, and safe school climate.

(c) Human Resources Management Performance Standard. The evaluatee fosters effective human resources management by assisting with selection and induction and by supporting, evaluating, and retaining quality instructional and support personnel.

(d) Organizational Management Performance Standard. The evaluatee fosters the success of all students by supporting, managing, and overseeing the school's organization, operation, and use of resources.

(e) Communication and Community Relations Performance Standard. The evaluatee fosters the success of all students by communicating and collaborating effectively with stakeholders.

(f) Professionalism Performance Standard. The evaluatee fosters the success of all students by demonstrating professional standards and ethics, engaging in continuous professional learning, and contributing to the profession.

(2) The district's professional practice rating evaluation form for assistant principals and principals shall list, in each standard, the performance criteria that characterize professional effectiveness and apply to the evaluatee.

(3) The district shall explain and discuss the professional practice rating standards, indicators, and performance criteria, and the evaluation process to assistant principal and principal evaluatees no later than the end of the evaluatee's first thirty (30) calendar days of the school year. Amendments to local systems of certified personnel evaluation approved by the department after the end of an evaluatee's first thirty (30) calendar days of the school year shall not apply to the evaluatee until the following school year.

(4) The district's professional practice rating evaluation form shall be specific to the evaluatee's job category. The district, at its discretion, may utilize forms for pre- and post-evaluation conferences.

(5) The evaluator shall utilize the Principal and Assistant Principal Performance Standards and the Principal and Assistant Principal Performance Standards Crosswalk, in compliance with KRS 156.557 and the requirements of this administrative regulation, to determine ratings for an assistant principal or principal evaluatee on each of the performance standards.

(6) The evaluator shall use evidence from professional growth plans and self-reflection, the department-approved survey of perception of superintendents, district personnel, and teachers on principal practice; and the department-approved working conditions survey goal. The evaluator shall also use evidence from site visits, for principals only. The evaluator may, if included in the district's approved evaluation plan, use additional district-determined sources of evidence to inform the evaluatee's rating on each of the six (6) standards listed in subsection (1) of this section.

(7) The evaluator shall use the following decision rules to determine a professional practice rating:

(a) If the evaluatee is rated exemplary in at least four (4) of the standards and no standard is rated developing or ineffective, the professional practice rating shall be exemplary;

(b) If the evaluatee is rated accomplished in at least four (4) standards and no standard is rated ineffective, the professional practice rating shall be accomplished;

(c) If the evaluatee is rated developing in at least five (5) standards, the professional practice rating shall be developing; and

(d) If the evaluatee is rated ineffective in two (2) or more standards, the professional practice rating shall be ineffective.

(8) The overall student growth rating for principals and assistant principals shall be determined as established in this subsection.

(a) The student growth measure for principals and assistant principals shall consist of a state contribution and a local contribution.

(b) The state contribution for principals and assistant principals shall be based on the degree to which the evaluatee meets the next generation learners goal. A principal's next generation learners goal shall be the assistant principal's next generation learners goal as well.

(c) The local contribution for the student growth measure for principals and assistant principals shall be a rating based on the degree to which the principal or assistant principal meets student growth goals. Assistant principals shall share the principal's student growth goals.

(d) All principals and assistant principals shall develop and implement a minimum of two (2) student growth goals each year, one (1) of which shall focus on school gap population data.

(e) One (1) goal shall address the needs outlined in the school's comprehensive school improvement plan.

(f) One (1) goal shall be based on local student growth data.

(g) The district shall ensure that student growth goals are rigorous and comparable across schools in the local district.

(h) The scale for low, expected, and high student growth goal ratings shall be determined by the local school district. In determining the scale, local school districts shall consider the schools goals and measures of success in the comprehensive school improvement plan required in 703 KAR 5:225, Section 9.

(i) The district shall develop a process for using professional judgment and evidence from the following sources of evidence to determine the overall student growth rating:

1. Growth trends over the three (3) most recent years of next generation learners student growth data, calculated pursuant to 703 KAR 5:200; and

2. Growth trends over the three (3) most recent years of student growth goal data.

Section 11. Overall Performance Category of Principals and Assistant Principals. (1) The overall performance category for principals and assistant principals shall be determined by combining the principal or assistant principal's professional practice rating and overall student growth rating, as illustrated by the Kentucky Professional Growth and Effectiveness System Model for Summative Evaluation of Assistant Principals and Principals.

(2) The district shall determine the overall performance category for principals and assistant principals with the decision rules established in this subsection.

(a) An evaluatee's overall performance category shall be exemplary if:

1. The professional practice rating is exemplary and the overall student growth rating is high;

2. The professional practice rating is exemplary and the overall student growth rating is expected; or

3. The professional practice rating is accomplished and the overall student growth rating is high.

(b) An evaluatee's overall performance category shall be accomplished if:

1. The professional practice rating is accomplished and the overall student growth rating is expected; or

2. The professional practice rating is developing and the overall student growth rating is high;

(c) An evaluatee's overall performance category shall be developing if:

1. The professional practice rating is exemplary and the overall student growth rating is low;

2. The professional practice rating is accomplished and the overall student growth rating is low;

3. The professional practice rating is developing and the overall student growth rating is expected; or

4. The professional practice rating is developing and the overall student growth rating is low.

(d) An evaluatee's overall performance category shall be ineffective if the professional practice rating is ineffective.

Section 12. Professional Growth Plan for Principals and Assistant Principals. The evaluator shall place an assistant principal or principal evaluatee on an appropriate professional growth plan based on the professional practice rating and the

overall student growth rating, as illustrated by the Kentucky Professional Growth Plan Model for Assistant Principals and Principals.

(1) An evaluatee whose professional practice rating is exemplary, with an expected to high overall student growth rating, shall have, at a minimum, a professional growth plan with goals set by the evaluatee with evaluator input and a summative evaluation that occurs at the end of each school year.

(2) An evaluatee whose professional practice rating is accomplished, with an expected to high student overall student growth rating, shall have, at a minimum, a professional growth plan with goals set by the evaluatee with evaluator input and a summative evaluation that occurs at the end of each school year.

(3) An evaluatee whose professional practice rating is developing, with a high overall student growth rating, shall have, at a minimum, a professional growth plan with goals set by the evaluatee with evaluator input and a summative evaluation that occurs at the end of each school year.

(4) An evaluatee whose professional practice rating is developing, with a low to expected overall student growth rating, shall have, at a minimum, a professional growth plan with goals determined by the evaluator and a summative evaluation at the end of each school year.

(5) An evaluatee whose professional practice rating is ineffective shall have, at a minimum, a professional growth plan with the goals determined by the evaluator and a summative evaluation at the end of the plan, as determined by the evaluator, not to exceed one (1) year in duration.

Section 13. Evaluation of Other Professionals and Preschool Teachers During the 2014-2015 School Year. (1) The district shall include, in its professional growth and effectiveness plan, a plan for the evaluation of other professionals and preschool teachers during the 2014-2015 school year.

(2) The district's procedures for other professional and preschool teacher evaluatees, whose evaluation cycle requires evaluation during the 2014-2015 school year, shall include the requirements established in this subsection.

(a) Beyond the minimum requirements set forth in this administrative regulation, the local district may establish requirements as to the length, frequency, and nature of observations conducted by an evaluator.

(b) The district shall require the evaluation to include a formative evaluation conference between the evaluator and the evaluatee within five (5) working days following each observation, the summative evaluation conference held at the end of an evaluation cycle that ends during the 2014-2015 school year, all evaluation data.

(c) The district shall require multiple observations to be conducted of an evaluatee who has earned continuing service status pursuant to KRS 161.740 and whose observation results are ineffective.

(d) The district shall require a summative evaluation to occur, if required by the evaluation cycle of the evaluatee.

(e) The district shall include the evaluation in the evaluatee's official personnel record.

(f) The district shall provide in the evaluation process an opportunity for a written response by the evaluatee and shall include the response in the evaluatee's official personnel record.

(g) A copy of the evaluation shall be provided to the evaluatee.

(3) The evaluation form shall include a list of performance criteria. Under each criterion, specific descriptors or indicators that can be measured or observed and recorded shall be listed. Additionally, standards of performance shall be established for each criterion. The performance criteria shall include those that are identified in KRS 156.557(4) that apply to the evaluatee.

(4) The evaluation criteria and process shall be explained to and discussed with the evaluatee no later than the end of the evaluatee's first thirty (30) calendar days of the 2014-2015 school year.

(5) An evaluative form shall be specific to each job category. The district, at its discretion, may use forms for pre- and post-evaluation conferences.

(6) The district shall provide evaluatees an opportunity for an appeal to the local evaluation appeals committee as outlined in Section 18 of this administrative regulation.

(7) An evaluatee who believes that the local district is not properly implementing the evaluation plan as approved by the department shall have the opportunity to appeal to the Kentucky Board of Education as outlined in Section 19 of this administrative regulation.

Section 14. Evaluation of Certified Administrators in the 2014-2015 School Year. (1) The district shall include, in the professional growth and effectiveness plan, a plan for the evaluation of certified administrators.

(2) Beyond the minimum requirements set forth in KRS 156.557 and this administrative regulation, the local district may establish requirements as to the length, frequency, and nature of observations conducted by an evaluator.

(3) The district shall require the evaluation to include a formative evaluation conference between the evaluator and the evaluatee within five (5) working days following each observation, the summative evaluation conference held at the end of the summative evaluation cycle, and the inclusion of all professional growth and effectiveness data.

(4) The district shall document the certified administrator's summative evaluation decision, shall include documentation of the sources of evidence used in determining the performance rating of the evaluatee, and shall include these documentations in the evaluatee's official personnel record.

(5) The district shall provide an opportunity for a written response by the evaluatee, and the response shall be included in the evaluatee's official personnel record.

(6) A copy of the evaluation shall be provided to the evaluatee.

(7) The evaluation form for certified administrators shall include a list of performance criteria that characterize effective administrative practices.

(8) Under each criterion, specific descriptors or indicators shall be listed.

(9) The performance criteria shall include those that are identified in KRS 156.557 that apply to the evaluatee.

(10) The evaluation criteria and process used to evaluate certified administrators shall be explained to and discussed with the evaluatee no later than the end of the evaluatee's first thirty (30) calendar days of the school year.

(11) The district's evaluation form shall be specific to the evaluatee's job category. The district, at its discretion, may utilize forms for pre- and post-evaluation conferences.

(12) The district shall provide certified administrator evaluatees an opportunity for an appeal to the local evaluation appeals committee as outlined in Section 18 of this administrative regulation.

(13) An evaluatee who believes that the local district is not properly implementing the evaluation plan as approved by the department shall have the opportunity to appeal to the Kentucky Board of Education as outlined in Section 19 of this administrative regulation.

Section 15. District Evaluation Plan. (1) The local board of education shall review, as needed, the district's evaluation plan to ensure compliance with KRS 156.557 and this administrative regulation.

(2) If a substantive change is made to the district's evaluation plan, the local board of education shall utilize the evaluation committee, described in KRS 156.557(5)(c)1, in formulating the revision. Examples of substantive change shall include changes in the evaluation cycle, observation frequency, forms, or appeal procedures.

(3) The local board of education shall review and approve revisions to the plan and submit the amended plan to the department for approval.

Section 16. Reporting. (1) Beginning in the 2014-2015 school year, districts shall report to the department the percentage of principals, assistant principals, and teachers in each overall

performance category listed in Sections 8 and 11 of this administrative regulation and the percentage of teachers on each plan listed in Section 9 of this administrative regulation.

(2) The department shall publicly report, by district, the aggregate number of principals, assistant principals, and teachers in each overall performance category.

Section 17. Monitoring. A district implementing an alternative professional growth and effectiveness plan approved by the department pursuant to KRS 156.557(7) shall be monitored within three (3) years of the initial implementation of the alternative plan, and subsequently at the discretion of the department.

Section 18. Local Evaluation Appeals Panel. The district shall provide in its system plan, for an appeal to the local evaluation appeals panel, the following:

(1) A right to a hearing as to every appeal;

(2) An opportunity, five (5) days in advance of the hearing, for the evaluator and evaluatee to adequately review all documents that are to be presented to the local evaluation appeals panel; and

(3) A right to presence of evaluatee's chosen representative.

Section 19. State Evaluation Appeals Panel. (1) A certified school personnel who believes that the local district is not properly implementing the evaluation plan as approved by the department shall have the opportunity to appeal to the Kentucky Board of Education.

(2) The appeal procedures shall be as established in this subsection.

(a) The Kentucky Board of Education shall appoint a committee of three (3) state board members to serve on the state evaluation appeals panel (SEAP). The SEAP's jurisdiction shall be limited to procedural matters already addressed by the local appeals panel or the district's failure to implement an evaluation plan as approved by the department. The SEAP shall not have jurisdiction of a complaint involving the professional judgment conclusion of an evaluation, and the SEAP's review shall be limited to the record of proceedings and documents therein, or lack thereof, at the local district level and any documents submitted pursuant to paragraph (c) of this subsection.

(b) No later than thirty (30) calendar days after the final action or decision at the local district level, a certified school personnel may submit a written request to the chief state school officer for a review before the SEAP. An appeal not filed in a timely manner shall not be considered. A specific description of the complaint and grounds for appeal shall be submitted with the request.

(c) A brief, written statement, or other document that a party wishes to submit for consideration by the SEAP shall be filed with the panel and served on the opposing party at least twenty (20) days prior to the scheduled review.

(d) A decision of the SEAP shall be rendered within fifteen (15) working days after the review.

(e) A determination of district noncompliance with the local evaluation plan or absence of a district local evaluation plan shall render the evaluation void, and the certified employee shall have the right to be reevaluated.

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

(a) "The Framework for Teaching Evaluation Instrument, 2011 Edition", May 2014;

(b) "Principal and Assistant Principal Performance Standards", May 2014;

(c) "Kentucky Professional Growth and Effectiveness System Model for Summative Evaluation of Teachers", May 2014;

(d) "Kentucky Professional Growth and Effectiveness System Model for Summative Evaluation of Assistant Principals and Principals", May 2014;

(e) "Teacher Evaluation Crosswalk", May 2014;

(f) "Principal and Assistant Principal Performance Standards Crosswalk", May 2014;

(g) "Kentucky Professional Growth Plan Model for Tenured Teachers", May 2014; and

(h) "Kentucky Professional Growth Plan Model for Assistant Principals and Principals", May 2014.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Education, 1st 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., Commissioner of Education
ROGER MARCUM, Chairperson

APPROVED BY AGENCY: April 15, 2014

FILED WITH LRC: April 15, 2014 at 11 a.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this proposed administrative regulation shall be held on May 22, 2014, at 10 a.m. in the State Board Room, First Floor, Capital Plaza Tower, 500 Mero Street, Frankfort, Kentucky. Individuals interested in being heard at this meeting 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 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 through close of business, June 2, 2014. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to:

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.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person: Kevin C. Brown

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes a statewide professional growth and effectiveness system, as required by KRS 156.557, for the evaluation and support and improvement of performance of all certified school personnel in school districts.

(b) The necessity of this administrative regulation: KRS 156.557 requires the agency to develop a framework for a statewide personnel evaluation system for all certified school personnel in school districts and to establish a statewide professional growth and effectiveness system for the evaluation and support and improvement of performance of all certified school personnel in school districts. This administrative regulation includes a framework for a statewide personnel evaluation system and establishes a uniform method of evaluation of certified school personnel in school districts.

(c) How this administrative regulation conforms to the content of the authorizing statute: As required by KRS 156.557, this administrative regulation establishes a uniform method of evaluation of certified school personnel in school districts.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation sets out the requirements for the uniform evaluation of certified school personnel, below the level of superintendent.

(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 statute:

(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: All public school districts 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: The administrative regulation will impact all schools and districts due to the implementation of a new certified school personnel evaluation system.

(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 districts shall provide training and resources to school and district personnel to ensure consistent and accurate implementation of the requirements of the statewide evaluation system for certified school personnel.

(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 to current operations.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Evaluation of certified school personnel will lead to the support and improvement of the performance of all certified school personnel and promote the continuous professional growth and development of skills needed to be a highly effective teacher or administrator.

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

(a) Initially: Any funds currently being spent in the local school district on teacher evaluation shall be redirected to address the requirements of KRS 156.557 and this administrative regulation. Local school districts should review how they use currently available state and federal grant funds (e.g. school improvement, Title I, Title II, Professional Development) for possible redirection to implementation of KRS 156.557 and this administrative regulation.

(b) On a continuing basis: Any funds currently being spent in the local school district on teacher evaluation shall be redirected to address the requirements of KRS 156.557 and this administrative regulation. Local school districts should review how they use currently available state and federal grant funds (e.g. school improvement, Title I, Title II, Professional Development) for possible redirection to implementation of KRS 156.557 and this administrative regulation.

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

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

(9) TIERING: Is tiering applied? No, tiering does not apply because the requirements of this administrative regulation apply to all school districts.

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 Kentucky public school districts.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 156.557.

(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? Any funds currently being spent in the local school district on teacher evaluation shall be redirected to address the requirements of KRS 156.557 and this administrative regulation. Local school districts should review how they use currently available state and federal grant funds (e.g. school improvement, Title I, Title II, Professional Development) for possible redirection to implementation of KRS 156.557 and this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? Any funds currently being spent in the local school district on teacher evaluation shall be redirected to address the requirements of KRS 156.557 and this administrative regulation. Local school districts should review how they use currently available state and federal grant funds (e.g. school improvement, Title I, Title II, Professional Development) for possible redirection to implementation of KRS 156.557 and 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 18:001. Definitions for 907 KAR Chapter 18.

RELATES TO: 42 U.S.C. 1396a(a)(13)(A), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. Part 413, 42 C.F.R. 447.204

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. 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 definitions for 907 KAR Chapter 18.

Section 1. Definitions. (1) "Allowable cost" means that portion of a facility's cost which may be allowed by the department for reimbursement purposes.

(2) "Ancillary service" means an ancillary service as established in 907 KAR 1:023.

(3) "Capital costs" means capital costs as established in 42 C.F.R. 413.130 through
157.

(4) "Cost report" means a copy of the cost report that a VA NF submits to the Medicare program.

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

(6) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(7) "Global Insight Index" means an indication of changes in health care costs from year to year developed by Global Insights Index.

(8) "Pro forma cost data" means estimated cost data for a

specific future period of time.

(9) "Prospective payment rate" means a payment rate for services based on allowable costs and other factors.

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

(11) "State fiscal year" means the twelve (12) month period beginning on July 1 of one year and ending on June 30 of the following year.

(12) "Upper payment limit" means an amount of reimbursement that:

(a) Equates to a Veterans Affairs nursing facility's Medicaid-allowable cost; and

(b) Does not exceed the limit established in 42 C.F.R. 447.272.

(13) "VA NF" means a nursing facility that is currently:

(a) Licensed by the Cabinet for Health and Family Services, Office of Inspector General as a nursing facility;

(b) Approved by the department for Medicaid program participation; and

(c) Certified by the United States Department of Veterans Affairs as a state veterans home.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: March 7, 2014

FILED WITH LRC: March 24, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 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 May 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 close of business, June 2, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the definitions for administrative regulations in 907 KAR Chapter 18. Chapter 18 contains an administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding Veterans Affairs nursing facility services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the definitions for administrative regulations in 907 KAR Chapter 18.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by establishing the definitions for administrative regulations in 907 KAR Chapter 18.

(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 the definitions for administrative regulations in 907 KAR Chapter 18.

(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: Veterans Affairs nursing facilities will be affected by the administrative regulation. Currently, there are three (3) such facilities operating in Kentucky – the Eastern Kentucky Veterans Center in Hazard, KY; the Thomson-Hood Veterans Center in Wilmore, KY; and the Western Kentucky Veterans Center in Hanson, KY. A fourth is scheduled to open in the autumn of 2015 in Radcliff, KY.

(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 as this administrative regulation establishes definitions for 907 KAR Chapter 18.

(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 administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Veterans Affairs nursing facilities will be benefit due to the clarity resulting from terms being defined in an administrative regulation.

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

(a) Initially: No cost is necessary to implement this administrative regulation.

(b) On a continuing basis: No 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: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the 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. 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 amendment neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the definitions apply equally to all entities regulated by this administrative regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

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

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

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

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

(c) How much will it cost to administer this program for the first year? DMS estimates that not cost is needed to implement this administrative regulation.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that no cost is needed 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 18:005. Reimbursement provisions and requirements regarding Veterans Affairs nursing facility services.

RELATES TO: 42 U.S.C. 1396a(a)(13)(A), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. Part 413, 42 C.F.R. 447.204

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. 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 Veterans Affairs nursing facility services in Kentucky.

Section 1. Provider Participation. To be eligible to be reimbursed for services under this administrative regulation, a VA NF shall be currently:

(1) Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(2) Participating in the Kentucky Medicaid Program in accordance with 907 1:671;

(3) Licensed by the Cabinet for Health and Family Services, Office of Inspector General as a nursing facility; and

(4) Certified as a state veterans home by the United States Department of Veterans Affairs.

Section 2. General Requirements. To be reimbursable by the department, a service shall be:

(1) Medically necessary;

(2) Provided to a recipient who is eligible for nursing facility services in accordance with 907 KAR 1:022;

(3) Provided in accordance with 907 KAR 1:022; and

(4) Provided by a VA NF that meets the requirements established in Section 1 of this administrative regulation.

Section 3. Covered Services. The following services, if provided by a VA NF in accordance with this administrative regulation, shall be covered under this administrative regulation:

(1) Nursing facility services;

(2) Ancillary services;

(3) Laboratory procedures or radiological services if ordered by a:

1. Physician;

2. An advanced practice registered nurse if the laboratory test or radiological service is within the scope of the advance practice registered nurse's practice; or

3. Physician assistant if:

a. Authorized by the supervising physician; and

b. The laboratory test or radiological service is within the scope of the physician assistant's practice; or

(4) Psychological or psychiatric therapy.

Section 4. Reimbursement. (1) The department shall reimburse a VA NF for services under this administrative regulation on a cost basis.

(2)(a) The cost basis shall include reimbursing:

1. A VA NF for services on an interim basis during a state fiscal year using a prospective payment rate; and

2. A final reimbursement to a VA NF for services for a state fiscal year:

a. Equal to the VA NF's Medicaid allowable cost for the state fiscal year; and

b. That results from a reconciliation of the:

(i) Interim prospective reimbursement paid by the department to the VA NF for the state fiscal year; and

(ii) Actual Medicaid allowable costs experienced by the VA NF for the state fiscal year as reflected on the cost report that has been desk reviewed and approved by the department for the state fiscal year.

(b)1. The prospective payment rate referenced in paragraph (a)1 of this subsection shall be:

a. Established using the most recently submitted cost report available to and reviewed by the department as of May 16 prior to the beginning of the state fiscal year; and

b. Trended and indexed to the midpoint of the state fiscal year.

2. For example, to set a prospective payment for a VA NF effective July 1, 2014, for the state fiscal year beginning July 1, 2014, the department shall:

a. Use the most recently submitted cost report available to the department as of May 16, 2013; and

b. Trend and index the prospective payment rate to December 31, 2013.

(3)(a) A prospective payment rate for services shall:

1. Be specific to the VA NF;

2. Not be subject to retroactive adjustment except as specified in this section;

3. Be determined by the department on a cost basis annually; and

4. Except as established in paragraph (b) of this subsection, be based on a VA NF's Medicaid allowable costs.

(b)1. If no cost report containing a full state fiscal year of cost data for a VA NF is available as of May 16, to set a prospective payment rate for the VA NF, the department shall:

a. If at least six (6) months of cost data is available, use pro forma cost data:

(i) Submitted to the department by the VA NF; and

(ii) Approved by the department; or

b. If less than six (6) months of cost data is available, establish a prospective payment rate equal to the statewide average prospective payment rate of existing VA NFs until the department receives a pro forma cost data including at least six (6) months of cost data.

2. Pro forma cost data shall be trended and indexed in the same way as established in subsection (2)(b) of this section.

(c) The department may adjust a prospective payment rate during the state fiscal year if the prospective payment rate that was established appears likely to result in a substantial cost settlement that could be avoided by adjusting the prospective payment rate.

(d)1. If the latest available cost report data has not been audited or desk-reviewed prior to rate setting for the universal year beginning July 1, a prospective rate based on a cost report which has not been audited or desk-reviewed shall be subject to adjustment when the audit or desk review is completed.

2. An unaudited cost report shall be subject to an adjustment to the audited amount after auditing has occurred.

(e)1. If the department has made a separate rate adjustment as compensation to a VA NF for a minimum wage update, the

department shall:

a. Not pay the VA NF twice for the same costs; and

b. Adjust downward the trending and indexing factors to the extent necessary to remove from the factors costs relating to the minimum wage updates already provided for by the separate rate adjustment.

2. If the trending and indexing factors include costs related to a minimum wage increase:

a. The department shall not make a separate rate adjustment; and

b. The minimum wage costs shall not be deleted from the trending and indexing factors.

(4) The department shall consider an adjustment to a VA NF's prospective rate (subject to the upper payment limit) if:

(a) The VA NF's increased costs are attributable to:

1. A governmentally imposed minimum wage increase, staffing ratio increase, or a level of service increase; and

2. The increase was not included in the Global Insight Index;

(b) A new licensure requirement or new interpretation of an existing requirement by the appropriate governmental agency as issued in an administrative regulation results in changes that affect all VA NFs; or

(c) The VA NF experiences a governmentally-imposed displacement of residents.

(5)(a) The amount of any prospective payment rate adjustment resulting from a governmentally-imposed minimum wage increase or licensure requirement change or interpretation as cited in subsection (4) of this section shall not exceed the amount by which the cost increase resulting directly from the governmental action exceeds on an annualized basis the inflation allowance amount included in the prospective rate for the general cost area in which the increase occurs.

1. For purposes of this determination, costs shall be classified as either:

a. Salaries; or

b. Other.

2. The effective date of an interim rate adjustment shall be the first day of the month in which the adjustment is requested or in which the cost increase occurred, whichever is later.

(6) A year-end adjustment of a prospective rate and a retroactive cost settlement adjustment shall be made if:

(a) An incorrect payment has been made due to a computational error (other than an omission of cost data) discovered in the cost basis or establishment of the prospective rate;

(b) An incorrect payment has been made due to a misrepresentation on the part of a facility (whether intentional or unintentional);

(c) A facility is sold and the funded depreciation account is not transferred to the purchaser; or

(d) The prospective rate has been set based on unaudited cost reports and the prospective rate is to be adjusted based on audited reports with the appropriate cost settlement made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.

(7)(a) The department shall retroactively cost settle reimbursement for services.

(b) Retroactive settlement shall entail:

1. Comparing interim prospective payments with the properly apportioned cost of Medicaid services rendered;

2. A tentative cost report settlement based upon:

a. Eighty (80) percent of any amount due the facility after a preliminary review is performed; or

b. 100 percent settlement of any liability due the department; and

3. A final cost report settlement after the allowed billing period has elapsed for the dates of service identified within the cost report.

(c) To be considered final, a cost report shall have been reviewed and approved by the department.

Section 5. Allowable and Non-allowable Costs. (1) Nursing facility services costs shall be the direct costs associated with nursing facility services.

(2)(a) Except as provided in paragraph (d) of this subsection, interest expense used in setting a prospective rate shall be an allowable cost if:

1. Permitted pursuant to 42 C.F.R. 413.153; and

2. The interest expense:

a. Represents interest on:

(i) Long term debt existing at the time the provider enters the program; or

(ii) New long-term debt, if the proceeds are used to purchase fixed assets relating to the provision of the appropriate level of care; or

b. Is for working capital and operating needs that directly relate to providing patient care.

(b) The forms of indebtedness may include:

1. Notes, advances, and various types of receivable financing; or

2. Mortgages, bonds, and debentures if the principal is to be repaid over a period in excess of one (1) year.

(c) If a debt is subject to variable interest rates found in balloon-type financing, renegotiated interest rates shall be allowable.

(d) Interest on a principal amount used to purchase goodwill or other intangible assets shall not be considered an allowable cost.

(3)(a) The allowable cost for a service or good purchased by a VA NF from a related organization shall be the cost to the related organization unless it can be demonstrated that the related organization is equivalent to a second party supplier.

(b) Except as provided in paragraph (c) of this subsection, an organization shall be considered a related organization if an individual possesses five (5) percent or more of ownership or equity in the facility and the supplying business.

(c) An organization shall not be considered a related organization if fifty-one (51) percent or more of the supplier's business activity of the type carried on with the VA NF is transacted with persons and organizations other than the VA NF and its related organizations.

(4) The amount allowable for leasing costs shall not exceed the amount which would be allowable based on the computation of historical costs.

(5) A cost shall be allowable and eligible for reimbursement if the cost is:

(a) Reflective of the provider's actual expenses of providing a service; and

(b) Related to Medicaid patient care pursuant to 42 C.F.R. 413.9.

(6) The following costs shall be allowable:

(a) Costs to related organizations pursuant to 42 C.F.R. 413.17;

(b) Costs of educational activities pursuant to 42 C.F.R. 413.85;

(c) Research costs pursuant to 42 C.F.R. 413.90;

(d) Value of services of nonpaid workers pursuant to 42 C.F.R. 413.94;

(e) Purchase discounts and allowances pursuant to 42 C.F.R. 413.98;

(f) Refunds of expenses pursuant to 42 C.F.R. 413.98;

(g) Depreciation on buildings and equipment if a cost is:

1. Identifiable and recorded in the provider's accounting records;

2. Based on historical cost of the asset or, if donated, the fair market value; or

3. Prorated over the estimated useful life of the asset using the straight-line method;

(h) Interest on current and capital indebtedness;

(i) Professional costs of services of full-time or regular part-time employees not to exceed what a prudent buyer would pay for comparable services; or

(j) A provider tax on a VA NF.

(7) The following costs shall not be allowable:

(a) The value of services provided by nonpaid members of an organization if there is an agreement with the provider to furnish the services at no cost;

(b) Political contributions;

(c) Legal fees for unsuccessful lawsuits against the Cabinet for Health and Family Services;

(d) Travel and associated costs outside of the Commonwealth of Kentucky to conventions, meetings, assemblies, conferences, or any related activities that are not related to NF training or educational purposes; or

(e) Costs related to lobbying.

(8) To determine the gain or loss on the sale of a facility for purposes of determining a purchaser's cost basis in relation to depreciation and interest costs, the following methods shall be used for changes of ownership occurring before July 18, 1984:

(a)1. Determine the actual gain on the sale of the facility; and

2. Add to the seller's depreciated basis two-thirds (2/3) of one (1) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller to arrive at the purchaser's cost basis;

(b) Gain shall be the amount in excess of a seller's depreciated basis as computed under program policies at the time of a sale, excluding the value of goodwill included in the purchase price;

(c)1. A sale shall be any bona fide transfer of legal ownership from an owner to a new owner for reasonable compensation, which shall usually be fair market value; and

2. A lease purchase agreement or other similar arrangement which does not result in a transfer of legal ownership from the original owner to the new owner shall not be considered a sale until legal ownership of the property is transferred; and

(d) If an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the purchaser's cost basis shall be determined pursuant to paragraphs (a) through (c) of this subsection.

(9)(a) An increase in valuation in relation to depreciation and interest costs shall not be allowed for changes of ownership occurring after July 18, 1984, and before October 1, 1985.

(b) For bona fide changes of ownership entered into on or after October 1, 1985, the depreciation and interest costs shall be increased in valuation in accordance with 42 U.S.C. 1395x(v)(1)(O)(i).

(10)(a) Maximum allowable costs shall be the maximum amount which may be allowed to a VA NF as reasonable cost for the provision of a supply or service while complying with limitations expressed in related federal or state regulations.

(b) Costs shall be subject to allowable cost limits pursuant to 42 C.F.R. 413.106.

Section 6. Cost Report Requirements. (1)(a) A VA NF shall, no later than five (5) months following the end of a state fiscal year, submit to the department a cost report stating the VA NF's costs for the state fiscal year.

(b) The time limit stated in paragraph (a) of this subsection may be extended at the specific request of the facility with the department's concurrence.

(2) If the VA NF experienced a new item or expansion representing a departure from current service levels and for which the VA NF requested prior approval by the department, the VA NF shall submit a supplement to the cost report to the department which:

(a) Describes the new item or expansion; and

(b) States the rationale for the new item or expansion.

(3)(a) Department approval or rejection of a projection or expansion shall be made on a prospective basis in the context that if an expansion and related costs are approved they shall be considered when actually incurred as an allowable cost.

(b) Rejection of an item or costs shall represent notice that the costs shall not be considered as part of the cost basis for reimbursement.

(c) Unless otherwise specified, approval shall relate to the substance and intent rather than the cost projection.

(d) If a request for prior approval of a projection or expansion is made, absence of a response by the department shall not be construed as approval of the item or expansion.

(4)(a) The department shall perform a desk review of each cost report to determine whether an audit is necessary and, if so, the scope of the audit.

(b) If the department determines that an audit is not necessary, the cost report shall be settled without an audit.

(c) A desk review or audit shall be used for purposes of verifying cost to be used in setting the prospective rate or for purposes of adjusting prospective rates which have been set based on unaudited data.

(d) Audits may be conducted annually or at less frequent intervals.

(5)(a) A VA NF shall maintain and make available any records and data necessary to justify and document:

1. Costs to the VA NF; and

2. Services performed by the VA NF.

(b) The department shall have unlimited on-site access to all of a VA NF's fiscal and service records for the purpose of:

1. Accounting;

2. Auditing;

3. Medical review;

4. Utilization control; or

5. Program planning.

Section 7. Preadmission Screening Resident Review (PASRR). (1) Prior to an admission of an individual to a VA NF, a VA NF shall conduct a level I PASRR in accordance with 907 KAR 1:755.

(2)(a) The department shall not reimburse a VA NF for a service delivered to an individual if the VA NF did not comply with the requirements of 907 KAR 1:755.

(b) Failure to comply with 907 KAR 1:755 may be grounds for termination of a VA NF's participation in the Medicaid Program.

Section 8. No Duplication of Service. The department shall not reimburse for a service provided by a VA NF to a recipient if the same service is provided at the same time to the recipient by another Medicaid program provider.

Section 9. Records Maintenance, Protection, and Security. (1)(a) A VA NF 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 VA NF 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 VA NF shall comply with 45 C.F.R. Part 164.

Section 10. Medicaid Program Participation Compliance. (1) A VA NF 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 VA NF receives any duplicate payment or overpayment from the department, regardless of reason, the VA NF 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 11. Third Party Liability. A VA NF shall comply with KRS 205.622.

Section 12. 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 VA NF 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 VA NF'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 VA NF's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 13. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 14. Federal Approval and Federal Financial Participation. The department's reimbursement and coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement and coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement and coverage.

Section 15. Drug Reimbursement. Drugs to a recipient in a VA NF shall:

(1) Be reimbursed via the department's outpatient pharmacy program in accordance with 907 KAR 1:018;

(2) Not be included in VA NF Medicaid allowable costs; and

(3) Not be reimbursed pursuant to this administrative regulation.

Section 16. Appeal Rights. A participating VA NF may appeal a department decision as to the application of this administrative regulation as it impacts the VA NF's reimbursement in accordance with 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: March 7, 2014

FILED WITH LRC: March 24, 2014 at 4 p.m.

PUBLIC HEARING AND PUBLIC COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on May 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 May 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 close of business, June 2, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, Kentucky 40601, phone (502) 564-7905, fax (502) 564-7573, email tricia.orme@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact: 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 regarding Veterans' Affairs nursing facility services.

(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish DMS's reimbursement provisions and requirements regarding Veterans' Affairs nursing facility services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: The administrative regulation conforms to the content of the authorizing statutes by establishing DMS's reimbursement provisions and requirements regarding Veterans' Affairs nursing facility 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 DMS's reimbursement provisions and requirements regarding Veterans' Affairs nursing facility 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: Veterans' Affairs nursing facilities will be affected by the amendment. Currently, there are three (3) such facilities operating in Kentucky – the Eastern Kentucky Veterans' Center in Hazard, KY; the Thomson-Hood Veterans Center in Wilmore, KY; and the Western Kentucky Veterans' Center in Hanson, KY. A fourth is scheduled to open in the autumn of 2015 in Radcliff, KY.

(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. Any Veterans' Affairs nursing facility which wishes to be reimbursed by the Kentucky Medicaid program must enroll with the Medicaid program by completing a provider agreement application and performing the actions required in the agreement. To be reimbursed for services VA nursing facilities will have to submit a cost report (documenting the facility's cost) to the department annually.

(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; however, a facility will experience administrative cost related to staff time involved in completing Medicaid program provider agreement.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Veterans' Affairs nursing facilities will be benefit by being reimbursed for services provided to Medicaid recipients and on a cost basis.

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

(a) Initially: The Kentucky Office of Veterans' Affairs (KOVA) will provide the state matching funds necessary to procure federal Medicaid funds; thus, the Department for Medicaid Services (DMS) will experience no cost to implement this administrative regulation. DMS projects annual expenditures in aggregate for the three (3) existing Veterans' Affairs nursing facilities in Kentucky to be

approximately $20.04 million ($6.01 million state funds/$14.03 million federal funds.)

(b) On a continuing basis: The response in (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: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from general fund and restricted fund appropriations are utilized to fund the 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. 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 not applied as the provisions and requirements apply equally to all Veterans' Affairs nursing facilities.

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)(13)(A), and 42 C.F.R. 447.204.

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.

3. Minimum or uniform standards contained in the federal mandate. 42 U.S. C. 1396a(a)(30)(A) 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 1396b(i)(4) of this title) 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."42 U.S.C. 1396a(a)(13)(A) requires "a public process for determination of rates of payment" for nursing facility services and services for intermediate care facilities for individuals with an intellectual disability. 42 C.F.R. 447.204 requires Medicaid programs' reimbursement to be "sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services 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? This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Neither stricter nor additional standards nor responsibilities are 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 the Kentucky Department of Veterans' Affairs 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 and 42 C.F.R. 447.204 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? The amount of revenues that the Veterans' Affairs nursing facilities in Kentucky will receive as a result of this administrative regulation is indeterminable due to the associated variables. A given facility's reimbursement will be based on their Medicaid allowable costs and that won't be accurately known until a facility experiences a full year of costs. Costs will depend on utilization including the number of Medicaid recipients receiving services during the state fiscal year from the given facility. Another variable is how soon a given facility enrolls in the Medicaid program.

(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 in (a) above also applies here.

(c) How much will it cost to administer this program for the first year? The Kentucky Office of Veterans' Affairs (KOVA) will provide the state matching funds necessary to procure federal Medicaid funds; thus, the Department for Medicaid Services (DMS) will experience no cost to implement this administrative regulation. DMS projects annual expenditures in aggregate for the three (3) existing Veterans' Affairs nursing facilities in Kentucky to be approximately $20.04 million ($6.01 million state funds/$14.03 million federal funds.)

(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:

ADMINISTRATIVE REGULATION REVIEW SUBCOMMITTEE
Minutes of April 14, 2014

Call to Order and Roll Call

The April 2014 meeting of the Administrative Regulation Review Subcommittee was held on Monday, April 14, 2014, at 9:00 a.m., in Room 149 of the Capitol Annex. Representative Johnny Bell, Co-chair, called the meeting to order, the roll call was taken. The minutes of the March 2014 meeting were approved.

Present were:

Members: Senators Perry Clark, Alice Forgy Kerr, Sara Beth Gregory; 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, and Betsy Cupp.

Guests: Becky Gilpatrick, Melissa F. Justice, Kentucky Higher Education Assistance Authority; Russ Salsman, Darren T. Sammons, Department for Local Government; Sonja Minch, Francis Simpson, Board of Barbering; Nathan Goldman, Paula Schenk, Board of Nursing; Mark Brengelman, Board of Physical Therapy; Ava Eaves, Angela Evans, Board of Certification for Dietitians and Nutritionists; Ron Brooks, Karen Waldrop, Kentucky Department of Fish and Wildlife Resources; Amy Barker, Department of Corrections; Kevin Brown, Robin Chandler, April Pieper, David Wickersham, Kentucky Department of Education; Lucretia Johnson, Pam Knight, Dwight Lovan, Charles E. Lowther, Department of Workers' Claims; Marc A. Guilfoil, Mary Scollay, Susan Speckert, John Ward, Kentucky Horse Racing Commission; Troi J. Cunningham, Paula Goff, C. Darrell Jennings, William Nold, David Edward Sponard, Cabinet for Health and Family Services; Landon Garrison, Sports Anglers; Toby Clark, David Cottrell, Richard Elliott, Heath Frailley, Alfred Gibson, Albert Knisley, Gary D. Nale, James Reed, Joseph R. Schigur, Robert Yockey; and George Tapp, Paylake Owner.

The Administrative Regulation Review Subcommittee met on Monday, April 14, 2014, and submits this report:

Administrative Regulations Reviewed by the Subcommittee:

KENTUCKY HIGHER EDUCATION ASSISTANCE AUTHORITY: Division of Student and Administrative Services: Authority

11 KAR 4:080. Student aid applications. Becky Gilpatrick, director of student aid services, and Melissa Justice, senior associate counsel, represented the division.

OFFICE OF THE GOVERNOR: Department for Local Government: Special Purpose Governmental Entities

109 KAR 16:010 & E. Special purpose governmental entities. Russ Salsman, chief of staff, and Darren Sammons, staff attorney, represented the department.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO paragraph to add a statutory citation; and (2) to amend Sections 1 through 7 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

GENERAL GOVERNMENT CABINET: Board of Barbering: Board

201 KAR 14:015. Retaking of examination. Sonja Minch, administrator, and Francis Simpson, chair, represented the board.

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 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 14:030. Five (5) year expiration of license.

A motion was made and seconded to approve the following amendments: 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 14:040. Inspection of shops and schools.

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 2 and 3 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 14:050. Probationary license; qualifications.

A motion was made and seconded to approve the following amendments: (1) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 1 through 3 to comply with the drafting requirements of KRS Chapter 13A; and (2) to create a new Section 5 to establish application requirements. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 14:052. Repeal of 201 KAR 14:051, 201 KAR 14:080, and 201 KAR 14:170.

201 KAR 14:060. Licensing requirements for qualified nonresidents.

A motion was made and seconded to approve the following amendments: 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 14:065. Place of business requirements.

A motion was made and seconded to approve the following amendment: to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 14:150. School records.

A motion was made and seconded to approve the following amendments: to amend Sections 1 and 3 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 14:180. License fees, examination fees, renewal fees, and expiration fees.

A motion was made and seconded to approve the following amendments: (1) to create a new Section 1 to establish fee requirements; and (2) to amend Sections 1 through 4 to comply with the formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Board of Nursing: Board

201 KAR 20:470. Dialysis technician credentialing requirements and training program standards. 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 paragraph to add statutory citations; (2) to amend Sections 1 through 13 to comply with the drafting and formatting requirements of KRS

Chapter 13A; (3) to amend Section 13 to clarify procedures if a dialysis technician is found by a chemical dependency evaluation, mental examination, or physical examination to be unable to practice safely and effectively; and (4) to create a new Section 14 to clarify that due process shall be in accordance with KRS Chapter 13B. Without objection, and with agreement of the agency, the amendments were approved.

Board of Physical Therapy: Board

201 KAR 22:001. Definitions for 201 KAR Chapter 22. Mark Brengelman, general counsel, represented the board.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO paragraph to add statutory citations; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Section 1 to comply with the drafting requirements of KRS Chapter 13A; and (3) to revise the REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT to correct an agency response. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 22:020. Eligibility and credentialing procedure.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO paragraph to correct statutory citations; (2) to amend Section 7 to comply with the drafting requirements of KRS Chapter 13A; and (3) to revise the REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT to correct an agency response. Without objection, and with agreement of the agency, the amendments were approved.

Board of Licensure and Certification for Dietitians and Nutritionists: Board

201 KAR 33:015. Application; approved programs. Ava Eaves, chair, and Angela Evans, assistant attorney general, represented the board.

A motion was made and seconded to approve the following amendments: (1) to amend Section 1 to: (a) require that an applicant for licensure or certification enclose, as an alternative to the copy of his or her registration card, a letter indicating the successful completion of the examination; and (b) clarify that the membership card issued by the Academy of Nutrition and Dietetics shall not comply with the requirements of the application for licensure or certification; (2) to amend Section 3 to update the material incorporated by reference; and (3) to revise the SUMMARY OF MATERIAL INCORPORATED BY REFERENCE to add statutory citations relating to nutritionists. Without objection, and with agreement of the agency, the amendments were approved.

201 KAR 33:070. Telehealth and telepractice.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO; STATUTORY AUTHORITY; and NECESSITY, FUNCTION, AND CONFORMITY paragraphs to correct 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 5 to comply with the drafting and formatting requirements of KRS Chapter 13A; (4) to amend Section 2 to: (1) provide examples of methods for a client to contact the practitioner; (b) require that the practitioner document the client's acknowledgement of the risks and limitations of telepractice; and (c) require that a practitioner include documentation on which services to the client were provided by telepractice; and (5) to revise the REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT to correct an agency response. Without objection, and with agreement of the agency, the amendments were approved.

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

301 KAR 1:155. Commercial fishing requirements. Ron Brooks, fisheries division director, and Karen Waldrop, wildlife division director, represented the department. Landon Garrison, sports angler, appeared in support of this administrative regulation. David Cottrell, Richard Elliot, Albert Knisley, and James Reed, commercial fishermen; Alford Gibson, fisherman; and George Tapp, pay lake owner, appeared in opposition to this administrative regulation.

In response to questions by Representative Turner, Mr. Brooks stated that the department held preliminary stakeholder meetings before receiving the biological data on which the new size limits were based. Those preliminary meetings were intended to be a starting point, not a firm agreement, and the size limits discussed at those meetings, including the "four (4) over forty (40)" limit, were not intended as a policy agreement. The second of the stakeholder meetings included an agreement by the department to conduct a five (5) year biological study; however, that study was not intended to be completed prior to an administrative regulation amendment. At the third stakeholder meeting, the department submitted a draft of the proposed administrative regulation amendment and requested stakeholder comments on the proposal. The matter was further discussed at the public fisheries meeting, and there was additional opportunity to submit comments during the public comment period conducted pursuant to KRS Chapter 13A. Biological data demonstrated a decrease in fish size around the Cannelton part of the Ohio River waterway. The proposed administrative regulation amendment represented a compromise between stakeholders and the department. Most commercial fishing in the Cannelton part of the Ohio River waterway was for fish transfer to area pay lakes.

In response to questions by Representative Turner, Mr. Reed stated that most commercial fishermen believed that the "four (4) over forty (40)" limit was a firm agreement made with the department. The commercial fishermen believed that would be the limit for the entire Ohio River waterway, not that there would be a different limit for the Cannelton area. Mr. Brooks stated that commercial fishermen below the Cannelton area dam were in agreement with this administrative regulation amendment, but commercial fishermen above the Cannelton area dam were not in agreement. Biological data demonstrated that fish above the Cannelton area dam were not replenished as readily and were less likely to migrate.

In response to a question by Senator Kerr, Mr. Brooks stated that the department was mandated to protect the fish resources.

Mr. Reed stated that the pay lake industry was essentially the only viable commercial fishing left in Kentucky. The pay lake industry brought trophy catfish popularity to Kentucky. Pay lake owners had made significant investments, and this administrative regulation amendment was overburdensome. Biologists did not supply sufficient data to support this administrative regulation amendment. The size limit would cause commercial fishermen to throw back approximately seventy (70) percent of each catch. This administrative regulation amendment would effectively shut down approximately 400 miles of waterway and jeopardize commercial fishing jobs and revenue.

Mr. Gibson stated that the only remaining viable industry for commercial fishermen in Kentucky was pay lakes because thirty (30) years ago the administration advised consumers not to eat channel catfish because of contamination.

In response to questions by Co-Chair Bell, Mr. Gibson stated that Cannelton area commercial fishermen were not aware of some of the stakeholder meetings and did not know there was a spokesperson who represented them. Mr. Cottrell stated that the commercial fishing industry dated to before George Washington's time. Commercial fishermen kept fish populations in balance, which improved the sport of fishing. The James River in Virginia established policies similar to those in this administrative regulation, and the effect on fishing was negative because fish populations became unbalanced. Mr. Garrison stated that this was a situation of the "tragedy of the commons." Sport fishermen wanted to protect the resource. Tournaments brought in revenue, but appropriately sized fish populations had become depleted.

In response to a question by Representative Lee, Mr.

Garrison stated that sports anglers caught, photographed, and returned fish. Mr. Brooks stated that the issue of concern was not that of overfishing, except pertaining to trophy-sized catfish. The department tried to reach all stakeholders for comments. Biological data was used to restrict only fishing requirements in the depleted area. Illinois, Indiana, Ohio, and Kentucky all contributed data for the biological reports. The issue of concern was that public fish populations would be damaged for private financial gain. Mr. Reed stated that, for the commercial fishing industry to remain viable, a market had to exist. The only current viable market was the pay lake industry. Twelve (12) percent of fishing licenses were pay lake-related. This administrative regulation amendment would destroy livelihoods without sufficient biological evidence supporting the department's position.

A motion was made and seconded to approve the following amendments: to amend Sections 1, 4 through 8, 10, 11, and 14 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Game

301 KAR 2:049. Small game and furbearer hunting and trapping on public and other federally owned areas.

A motion was made and seconded to approve the following amendments: to amend Sections 3 through 6, 9, and 10 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

301 KAR 2:126. Repeal of 301 KAR 2:125.

301 KAR 2:251. Hunting and trapping seasons and limits for furbearers.

A motion was made and seconded to approve the following amendments: (1) to amend Section 6 to establish that, except as established in 301 KAR 2:049, trapping season for furbearers shall begin one-half hour before sunrise on the third day of the modern gun deer season; (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Sections 1 through 6, 10, and 11 to comply with the drafting requirements of KRS Chapter 13A; and (3) to create a new Section 12 to incorporate the application form by reference. Without objection, and with agreement of the agency, the amendments were approved.

JUSTICE AND PUBLIC SAFETY CABINET: Department of Corrections: Office of the Secretary

501 KAR 6:170. Green River Correctional Complex. Amy Barker, assistant general counsel, represented the department.

A motion was made and seconded to approve the following amendments: to amend Section 1 and the material incorporated by reference to: (1) update citations; (2) clarify various provisions; and (3) comply with the drafting and formatting requirements of KRS Chapter 13A. 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 Administration and Finance

702 KAR 3:300. Approval for school district lease and retirement incentive annuity agreements. Kevin Brown, general counsel, represented the department.

A motion was made and seconded to approve the following amendments: (1) to amend the STATUTORY AUTHORITY paragraph and Section 1 to correct a statutory citation; and (2) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph and Section 3 to comply with the drafting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Office of Learning Support Services

704 KAR 7:151. Repeal of 704 KAR 7:150.

LABOR CABINET: Department of Workers' Claims: Workers' Claims

803 KAR 25:089. Workers' compensation medical fee schedule for physicians. Dwight Lovin, Commissioner, represented the department.

PUBLIC PROTECTION CABINET: Kentucky Horse Racing Commission: Thoroughbred Racing

810 KAR 1:040. Drug, medication, and substance classification schedule and withdrawal guidelines. Marc Guilfoil, director; Dr. Mary Scollay, equine medical director; and Susan Speckert, general counsel, represented the commission.

Harness Racing

811 KAR 1:090. Medication; testing procedures; prohibited practices.

A motion was made and seconded to approve the following amendments: (1) to amend the NECESSITY, FUNCTION, AND CONFORMITY paragraph to correct a statutory citation; and (2) to amend Sections 6, 8, 10, 12 through 15, 17, and 20 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

811 KAR 1:093. Drug, medication, and substance classification schedule and withdrawal guidelines.

811 KAR 1:095. Disciplinary measures and penalties.

A motion was made and seconded to approve the following amendments: (1) to amend Section 2 to delete duplicative text; and (2) to amend Sections 5 and 9 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

Quarter Horse, Appaloosa and Arabian Racing

811 KAR 2:093. Drug, medication, and substance classification schedule and withdrawal guidelines.

CABINET FOR HEALTH AND FAMILY SERVICES: Office of the Kentucky Health Benefit Exchange: Kentucky Health Benefit Exchange

900 KAR 10:100 & E. Appeals of Eligibility Determinations for KHBE Participation and Insurance Affordability Programs. William Nold, deputy executive director, represented the cabinet.

In response to a question by Senator Gregory, Mr. Nold stated that this administrative regulation did relate to the Affordable Care Act.

A motion was made, without a second, to find this administrative regulation deficient based on lack of statutory authority. Because there was not a second, the motion failed.

A motion was made and seconded to approve the following amendments: (1) to amend the RELATES TO and NECESSITY, FUNCTION, AND CONFORMITY paragraphs and Sections 1, 2, and 13 to correct statutory citations; and (2) to amend Sections 1, 4 through 10, 12, and 13 to comply with the drafting and formatting requirements of KRS Chapter 13A. Without objection, and with agreement of the agency, the amendments were approved.

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

902 KAR 4:030. Newborn Screening Program. Troi Cunningham, nurse administrator, and Dr. C. D. Jennings, director of the state newborn screening laboratory, represented the cabinet.

A motion was made and seconded to approve the following amendments: (1) to amend Section 3 to update citations; (2) to amend Sections 3 and 11 to clarify how test results are reported to the cabinet; (3) to amend Sections 3 and 9 to specify exceptions; (4) to amend Section 10 to clarify procedures for pending pulse oximetry results; (5) to amend Sections 1 through 4, 7, and 10 to comply with the drafting requirements of KRS Chapter

13A; and (6) to amend Section 2 to require newborn screening for Severe Combined Immunodeficiency (SCID). Without objection, and with agreement of the agency, the amendments were approved.

Other Business: A motion was made by Representative Turner and seconded by Representative Damron to consider 301 KAR 10:031 at the May 13 meeting of the Subcommittee. Without objection, the motion was approved.

The following administrative regulations were deferred to the May 13, 2014, meeting of the Subcommittee:

OFFICE OF THE GOVERNOR: Department for Local Government: County Budget

109 KAR 15:020. County Budget Preparation and State Local Finance Officer Policy Manual.

GENERAL GOVERNMENT CABINET: Board of Barbering: Board

201 KAR 14:085. Sanitation requirements.

201 KAR 14:090. School curriculum.

201 KAR 14:115. Examinations; school and board.

Board of Physical Therapy: Board

201 KAR 22:160. Telehealth and telephysical therapy.

JUSTICE AND PUBLIC SAFETY CABINET: Department of State Police: Driver Testing Branch: Breath Analysis Operators

500 KAR 8:030. Administration of breath alcohol tests and chemical analysis tests.

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

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

CABINET FOR HEALTH AND FAMILY SERVICES: Department for Medicaid Services: Medicaid Services

907 KAR 1:039 & E. Hearing Program reimbursement provisions and requirements.

Hospital Service Coverage and Reimbursement

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

Private Duty Nursing

907 KAR 13:015 & E. Private duty nursing service reimbursement provisions and requirements.

Department for Behavioral Health, Developmental and Intellectual Disabilities: Division for Behavioral Health: Mental Health

908 KAR 2:240 & E. Kentucky Youth Peer Support Specialist.

908 KAR 2:250 & E. Community support associate; eligibility criteria and training.

The Subcommittee adjourned at 2 p.m. until May 13, 2014 at 1 p.m.

OTHER COMMITTEE REPORTS

COMPILER'S NOTE: In accordance with KRS 13A.290(9), the following reports were forwarded to the Legislative Research Commission by the appropriate jurisdictional committees and are hereby printed in the Administrative Register. The administrative regulations listed in each report became effective upon adjournment of the committee meeting at which they were considered.

EDUCATION ASSESSMENT AND ACCOUNTABILITY REVIEW SUBCOMMITTEE
Meeting of March 26, 2014

The following administrative regulations were available for consideration and placed on the agenda of the Education Assessment and Accountability Review Subcommittee for its meeting of March 26, 2014, having been referred to the Subcommittee on February 14, 2014, pursuant to KRS 13A.290(6):

703 KAR 5:070
703 KAR 5:080 and E

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 March 26, 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 **K - 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 **K - 15**

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 **K - 29**

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 **K - 30**

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.

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 39 (last year's) issues of the Administrative Register but had not yet gone into effect when the 12 bound Volumes were published.

SYMBOL KEY:

* Statement of Consideration not filed by deadline
** Withdrawn before being printed in Register
**** Emergency expired after 180 days
‡ Withdrawn deferred more than twelve months (KRS 13A.300(4) and 13A.315(1)(d))
(r) Repealer regulation: KRS 13A.310-on the effective date of an administrative regulation that repeals another, the regulations compiler shall delete the repealed administrative regulation and the repealing administrative regulation.

EMERGENCY ADMINISTRATIVE REGULATIONS:

(Note: Emergency regulations expire 180 days from the date filed; or 180 days from the date filed plus number of days of requested extension, or upon replacement or repeal, whichever occurs first.)

103 KAR 3:040E	1862	1-15-13
Replaced	1920	5-31-13
301 KAR 2:195E	1574	12-28-12
Replaced	2018	5-3-13
900 KAR 10:010E	2296	5-13-13
Replaced	1075	12-10-13
907 KAR 1:055E	1987	3-1-13
Replaced	299	9-6-13
907 KAR 1:056E*(r)*	1993	3-1-13
Expired		8-28-13
907 KAR 1:711E	1587	12-21-12
Expired		6-19-13
907 KAR 3:015E	2112	4-3-13
Replaced		See 40 Ky.R.
907 KAR 3:225E	2301	5-8-13
Replaced	844	11-1-13
907 KAR 3:230E	2306	5-8-13
Replaced	848	11-1-13
907 KAR 17:005E	1589	12-21-12
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907 KAR 17:010E	1610	12-21-12
Replaced	2343	6-27-13
907 KAR 17:015E	1620	12-21-12
Replaced	2350	6-27-13
907 KAR 17:020E	1625	12-21-12
Replaced	2353	6-27-13
907 KAR 17:025E	1630	12-21-12
Replaced	2356	6-27-13
907 KAR 17:030E	1635	12-21-12
Replaced	1846	6-27-13
921 KAR 2:015E	1639	12-21-12
Replaced	1813	6-19-13
921 KAR 3:090E	2115	3-28-13
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922 KAR 1:130E	2117	3-28-13
Replaced	550	9-18-13
922 KAR 1:140E	2122	3-28-13
Replaced	554	9-18-13
922 KAR 1:320E	2126	3-28-13
Replaced	556	9-18-13
922 KAR 1:400E	2130	3-28-13
Replaced	559	9-18-13
922 KAR 2:090E	2134	3-27-13
Replaced	305	9-18-13
922 KAR 2:160E	2140	3-27-13
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17 KAR 3:040	1963	7-5-13
101 KAR 2:076		
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101 KAR 2:095		
Amended	2362	(See 40 Ky.R.)
101 KAR 2:102		
Amended	2365	(See 40 Ky.R.)
101 KAR 3:015		
Amended	2370	(See 40 Ky.R.)
101 KAR 3:050		
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201 KAR 2:074		
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201 KAR 18:040		
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201 KAR 18:072		
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201 KAR 18:142		
Amended	2383	(See 40 Ky.R.)
201 KAR 20:020		
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201 KAR 20:057		
Amended	2191	(See 40 Ky.R.)
201 KAR 20:059		
Amended	2046	
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201 KAR 20:070		
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201 KAR 20:085		
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201 KAR 20:110		
Amended	2197	7-17-2013
201 KAR 20:380		
Repealed	1820	5-3-13
201 KAR 20:400		
Amended	2047	(See 40 Ky.R.)
201 KAR 20:500		
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201 KAR 31:010		
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201 KAR 31:050		
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201 KAR 31:060		
Amended	2391	(See 40 Ky.R.)
201 KAR 31:080		
Amended	2393	(See 40 Ky.R.)
201 KAR 31:090		
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202 KAR 7:330		
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202 KAR 7:540	2092	(See 40 Ky.R.)
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301 KAR 1:122		
Amended	2201	(See 40 Ky.R.)
301 KAR 2:049		
Amended	2061	6-6-13
301 KAR 2:122		
Amended	2064	6-6-13
301 KAR 2:251		
Amended	2397	(See 40 Ky.R.)
401 KAR 10:030		
Amended	584	
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401 KAR 5:320	2094	(See 40 Ky.R.)
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503 KAR 1:170		
Amended	2066	
As Amended	2317	7-5-13
505 KAR 1:160		
Amended	1952	
As Amended	2173	5-31-13
601 KAR 9:135		
Amended	1953	5-31-13
702 KAR 3:130		
Amended	1321	
Amended	1891	
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702 KAR 4:160		
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703 KAR 5:121(r)	2098	
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703 KAR 5:250	2099	
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787 KAR 1:010		
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787 KAR 1:290		
Amended	2401	9-6-13
804 KAR 9:040		
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Amended	2178	
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804 KAR 9:050		
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815 KAR 7:120		
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815 KAR 20:020		
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815 KAR 20:034		
Amended	2208	(See 40 Ky.R.)
815 KAR 20:120		
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900 KAR 5:020		
Amended	1322	
Amended	1895	
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Amended	2403	(See 40 Ky.R.)
902 KAR 30:120		
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902 KAR 30:130		
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902 KAR 30:150		
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902 KAR 30:160		
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902 KAR 30:200		
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902 KAR 55:110		
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Amended	335	
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907 KAR 1:055		
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907 KAR 1:090		
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907 KAR 1:092		
Repealed	2448	9-6-13
907 KAR 1:320		
Repealed	2448	9-6-13
907 KAR 10:017		
Repealed	2448	9-6-13
907 KAR 10:372		
Repealed	2448	9-6-13
907 KAR 10:376		
Repealed	2448	9-6-13
907 KAR 1:563		
Amended	2434	(See 40 Ky.R.)
907 KAR 1:595		
Amended	2438	12-2-11
907 KAR 3:225	2449	(See 40 Ky.R.)
907 KAR 3:230	2454	(See 40 Ky.R.)
907 KAR 3:015	2284	(See 40 Ky.R.)
907 KAR 17:005		
Amended	1792	
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907 KAR 17:010	1822	
Amended	2181	
As Amended	2343	6-27-13
907 KAR 17:015	1831	
As Amended	2350	6-27-13
907 KAR 17:020	1836	
As Amended	2353	6-27-13
907 KAR 17:025	1841	
As Amended	2356	6-27-13
907 KAR 17:030	1846	6-27-13
921 KAR 2:015		
Amended	1813	6-19-13
921 KAR 3:090		
Amended	2218	(See 40 Ky.R.)
922 KAR 1:130		
Amended	2220	(See 40 Ky.R.)
922 KAR 1:140		
Amended	2225	(See 40 Ky.R.)
922 KAR 1:320		
Amended	2228	(See 40 Ky.R.)
922 KAR 1:400		
Amended	2233	(See 40 Ky.R.)
922 KAR 2:020		
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922 KAR 2:090		
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922 KAR 2:110		
Amended	2256	(See 40 Ky.R.)
922 KAR 2:120		
Amended	2261	(See 40 Ky.R.)
922 KAR 2:160		
Amended	2269	(See 40 Ky.R.)
922 KAR 2:180		
Amended	2278	9-18-13

SYMBOL KEY:
* Statement of Consideration not filed by deadline
** Withdrawn before being printed in Register
‡ Withdrawn, deferred more than twelve months (KRS 13A.300(4) and 13A.315(1)(d))
(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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SYMBOL KEY:
* Statement of Consideration not filed by deadline
** Withdrawn before being printed in Register
**** Emergency expired after 180 days
(r) Repealer regulation: KRS 13A.310-on the effective date of an administrative regulation that repeals another, the regulations compiler shall delete the repealed administrative regulation and the repealing administrative regulation.

EMERGENCY ADMINISTRATIVE REGULATIONS:
(Note: Emergency regulations expire 180 days from the date filed; or 180 days from the date filed plus number of days of requested extension, or upon replacement or repeal, whichever occurs first.)

30 KAR 5:010E	219	6-28-13
Replaced	775	11-1-13
30 KAR 5:020E	220	6-28-13
Replaced	775	11-1-13
30 KAR 5:030E	223	6-28-13
Replaced	777	11-1-13
30 KAR 5:040E	225	6-28-13
Replaced	777	11-1-13
30 KAR 5:050E	228	6-28-13
Replaced	780	11-1-13
30 KAR 5:060E	230	6-28-13
Replaced	781	11-1-13
30 KAR 6:010E	2401	3-24-14
31 KAR 4:070E	755	9-4-13
Replaced	882	1-3-14
101 KAR 2:210E	756	9-9-13
Replaced	884	1-3-14
103 KAR 3:010E	1529	12-27-13
Replaced		5-2-14
103 KAR 3:020E	1534	12-27-13
Replaced		5-2-14
103 KAR 3:030E	1540	12-27-13
Replaced		5-2-14
103 KAR 3:040E	1550	12-27-13
Replaced		5-2-14
105 KAR 1:140E	233	7-01-13
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109 KAR 16:010E	1561	12-18-13
201 KAR 22:055E	4	5-15-13
Withdrawn		9-17-13
201 KAR 30:315E	935	10-10-13
Replaced	1396	2-3-14
301 KAR 2:221E	1232	10-21-13
Replaced	1725	3-7-14
301 KAR 2:222E	1234	10-21-13
Replaced	1726	3-7-14
301 KAR 2:225E	524	8-14-13
Replaced	1045	11-7-13
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405 KAR 10:070E	240	7-03-13
Replaced	1065	11-7-13
405 KAR 10:080E	243	7-03-13
Replaced	1066	11-7-13
405 KAR 10:090E	245	7-03-2013
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405 KAR 10:201E	246	7-03-13
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501 KAR 6:020E	759	8-20-13
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505 KAR 1:170E	936	10-14-2013
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Replaced	1398	2-3-14
804 KAR 4:390E	5	6-14-13
Replaced	170	10-4-13
804 KAR 4:400E	247	6-25-13
Replaced	811	11-1-13
804 KAR 4:410E	249	6-25-13
Replaced	811	11-1-13
804 KAR 4:430E	7	6-14-13
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815 KAR 4:030E	250	6-25-13
Replaced	824	10-23-13
815 KAR 4:040E	253	6-25-13
Replaced	825	10-23-13
900 KAR 5:020E	761	8-30-13
Replaced	894	1-15-14
900 KAR 7:030E	1564	12-17-13
Replaced	1929	5-2-14
900 KAR 10:020E	8	6-07-13
Replaced	1080	12-10-13
900 KAR 10:030E	762	8-22-13
Replaced	1283	1-3-14
900 KAR 10:050E	255	7-10-13
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907 KAR 1:019E	1573	12-30-13
907 KAR 1:030E	1581	12-26-13
907 KAR 1:038E	1585	12-26-13
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907 KAR 1:604E	1631	12-26-13
907 KAR 1:631E	1638	12-26-13
907 KAR 1:632E	1642	12-26-13
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907 KAR 3:005E	1648	12-26-13
907 KAR 3:015E		See 39 Ky.R.
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907 KAR 8:005E	1655	12-26-13
907 KAR 8:010E	1657	
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907 KAR 8:015E	1660	12-26-13
907 KAR 8:020E	1662	12-26-13
907 KAR 8:025E	1665	12-26-13

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907 KAR 13:005E	1677	12-26-13
907 KAR 13:010E	1680	12-26-13
907 KAR 13:015E	1683	12-26-13
907 KAR 15:005E	1686	12-30-13
907 KAR 15:010E	1688	12-30-13
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907 KAR 15:015E	1691	12-30-13
907 KAR 18:001E	2404	3-24-14
907 KAR 18:005E	2405	3-24-14
907 KAR 20:001E	938	9-30-2013
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907 KAR 20:005E	944	9-30-2013
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907 KAR 20:010E	952	9-30-2013
Replaced		4-14-14
907 KAR 20:015E	956	9-30-2013
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907 KAR 20:025E	964	9-30-2013
Replaced		4-14-14
907 KAR 20:030E	969	9-30-2013
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907 KAR 20:035E	974	9-30-2013
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907 KAR 20:045E	983	9-30-2013
Replaced		4-14-14
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907 KAR 20:060E	990	9-30-2013
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907 KAR 20:075E	993	9-30-13
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907 KAR 20:100E	997	9-30-13
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908 KAR 2:240E	2112	2-6-14
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921 KAR 2:015E	1238	11-14-13
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12 KAR 1:145		
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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
‡ Withdrawn deferred more than twelve months (KRS 13A.300(4) and 13A.315(1)(d))
(r) Repealer regulation: KRS 13A.310-on the effective date of an administrative regulation that repeals another, the regulations compiler shall delete the repealed administrative regulation and the repealing administrative regulation.

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The Technical Amendment Index is a list of administrative regulations which have had technical, nonsubstantive amendments entered since being published in the *2013 Kentucky Administrative Regulations Service*. These technical changes have been made by the Regulations Compiler pursuant to KRS 13A.040(9) and (10), 13A.312(2), or 13A.320(1)(d). Since these changes were not substantive in nature, administrative regulations appearing in this index will NOT be published to show the technical corrections in the *Administrative Register of Kentucky*. NOTE: Finalized copies of the technically amended administrative regulations are available for viewing on the Legislative Research Commission Web site at http://www.lrc.ky.gov/home.htm.

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