AN ACT relating to elimination of the certificate of need.

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

➔Section 1. KRS 13B.020 is amended to read as follows:

(1) The provisions of this chapter shall apply to all administrative hearings conducted by an agency, with the exception of those specifically exempted under this section. The provisions of this chapter shall supersede any other provisions of the Kentucky Revised Statutes and administrative regulations, unless exempted under this section, to the extent these other provisions are duplicative or in conflict. This chapter creates only procedural rights and shall not be construed to confer upon any person a right to hearing not expressly provided by law.

(2) The provisions of this chapter shall not apply to:

(a) Investigations, hearings to determine probable cause, or any other type of information gathering or fact finding activities;

(b) Public hearings required in KRS Chapter 13A for the promulgation of administrative regulations;

(c) Any other public hearing conducted by an administrative agency which is nonadjudicatory in nature and the primary purpose of which is to seek public input on public policy making;

(d) Military adjudicatory proceedings conducted in accordance with KRS Chapter 35;

(e) Administrative hearings conducted by the legislative and judicial branches of state government;

(f) Administrative hearings conducted by any city, county, urban-county, charter county, or special district contained in KRS Chapters 65 to 109, or any other unit of local government operating strictly in a local jurisdictional capacity;

(g) Informal hearings which are part of a multilevel hearing process that affords an administrative hearing at some point in the hearing process if the

procedures for informal hearings are approved and promulgated in accordance with subsections (4) and (5) of this section;

(h) Limited exemptions granted for specific hearing provisions and denoted by reference in the text of the applicable statutes or administrative regulations;

(i) Administrative hearings exempted pursuant to subsection (3) of this section;

(j) Administrative hearings exempted, in whole or in part, pursuant to subsections (4) and (5) of this section; and

(k) Any administrative hearing which was commenced but not completed prior to July 15, 1996.

(3) The following administrative hearings are exempt from application of this chapter in compliance with 1994 Ky. Acts ch. 382, sec. 19:

(a) Finance and Administration Cabinet

1. Higher Education Assistance Authority

a. Wage garnishment hearings conducted under authority of 20 U.S.C. sec. 1095a and 34 C.F.R. sec. 682.410

b. Offset hearings conducted under authority of 31 U.S.C. sec. 3720A and sec. 3716, and 34 C.F.R. sec. 30.33

2. Department of Revenue

a. Any licensing and bond revocation hearings conducted under the authority of KRS 138.210 to 138.448 and 234.310 to 234.440

b. Any license revocation hearings under KRS 131.630 and 138.130 to 138.205

(b) Cabinet for Health and Family Services

1. Office of Health Policy

a. ~~[Certificate-of-need hearings and]~~Licensure ***hearings*** conducted under authority of KRS Chapter 216B

b. Licensure revocation hearings conducted under authority of KRS

Chapter 216B

2. Department for Community Based Services

a. Supervised placement revocation hearings conducted under authority of KRS Chapter 630

3. Department for Income Support

a. Disability determination hearings conducted under authority of 20 C.F.R. sec. 404

4. Department for Medicaid Services

a. Administrative appeal hearings following an external independent third-party review of a Medicaid managed care organization's final decision that denies, in whole or in part, a health care service to an enrollee or a claim for reimbursement to the provider for a health care service rendered by the provider to an enrollee of the Medicaid managed care organization, conducted under authority of KRS 205.646

(c) Justice and Public Safety Cabinet

1. Department of Kentucky State Police

a. Kentucky State Police Trial Board disciplinary hearings conducted under authority of KRS Chapter 16

2. Department of Corrections

a. Parole Board hearings conducted under authority of KRS Chapter 439

b. Prison adjustment committee hearings conducted under authority of KRS Chapter 197

c. Prison grievance committee hearings conducted under authority of KRS Chapters 196 and 197

3. Department of Juvenile Justice

a. Supervised placement revocation hearings conducted under KRS Chapter 635

(d) Energy and Environment Cabinet

1. Department for Natural Resources

a. Surface mining hearings conducted under authority of KRS Chapter 350

2. Department for Environmental Protection

a. Wild River hearings conducted under authority of KRS Chapter 146

b. Water resources hearings conducted under authority of KRS Chapter 151

c. Water plant operator and water well driller hearings conducted under authority of KRS Chapter 223

d. Environmental protection hearings conducted under authority of KRS Chapter 224

e. Petroleum Storage Tank Environmental Assurance Fund hearings under authority of KRS Chapter 224

3. Public Service Commission

a. Utility hearings conducted under authority of KRS Chapters 74, 278, and 279

(e) Labor Cabinet

1. Department of Workers' Claims

a. Workers' compensation hearings conducted under authority of KRS Chapter 342

2. Kentucky Occupational Safety and Health Review Commission

a. Occupational safety and health hearings conducted under authority of KRS Chapter 338

(f) Public Protection Cabinet

1. Kentucky Claims Commission

a. Liability hearings conducted under authority of KRS 49.020(1) and 49.040 to 49.180

(g) Education and Workforce Development Cabinet

1. Unemployment Insurance hearings conducted under authority of KRS Chapter 341

(h) Secretary of State

1. Registry of Election Finance

a. Campaign finance hearings conducted under authority of KRS Chapter 121

(i) State universities and colleges

1. Student suspension and expulsion hearings conducted under authority of KRS Chapter 164

2. University presidents and faculty removal hearings conducted under authority of KRS Chapter 164

3. Campus residency hearings conducted under authority of KRS Chapter 164

4. Family Education Rights to Privacy Act hearings conducted under authority of 20 U.S.C. sec. 1232 and 34 C.F.R. sec. 99

5. Federal Health Care Quality Improvement Act of 1986 hearings conducted under authority of 42 U.S.C. sec. 11101 to 11115 and KRS Chapter 311.

(4) Any administrative hearing, or portion thereof, may be certified as exempt by the Attorney General based on the following criteria:

(a) The provisions of this chapter conflict with any provision of federal law or regulation with which the agency must comply, or with any federal law or

regulation with which the agency must comply to permit the agency or persons within the Commonwealth to receive federal tax benefits or federal funds or other benefits;

(b) Conformity with the requirement of this chapter from which exemption is sought would be so unreasonable or so impractical as to deny due process because of undue delay in the conduct of administrative hearings; or

(c) The hearing procedures represent informal proceedings which are the preliminary stages or the review stages of a multilevel hearing process, if the provisions of this chapter or the provisions of a substantially equivalent hearing procedure exempted under subsection (3) of this section are applied at some level within the multilevel process.

(5) The Attorney General shall not exempt an agency from any requirement of this chapter until the agency establishes alternative procedures by administrative regulation which, insofar as practical, shall be consistent with the intent and purpose of this chapter. When regulations for alternative procedures are submitted to the Administrative Regulation Review Subcommittee, they shall be accompanied by the request for exemption and the approval of exemption from the Attorney General. The decision of the Attorney General, whether affirmative or negative, shall be subject to judicial review in the Franklin Circuit Court within thirty (30) days of the date of issuance. The court shall not overturn a decision of the Attorney General unless the decision was arbitrary or capricious or contrary to law.

(6) Except to the extent precluded by another provision of law, a person may waive any procedural right conferred upon that person by this chapter.

➔Section 2. KRS 79.080 is amended to read as follows:

(1) The term "health maintenance organization" for the purposes of this section, means a health maintenance organization as defined in KRS 304.38-030, which has been licensed by the ***Cabinet for Health and Family Services***~~[Kentucky Health Facilities~~

~~and Health Services Certificate of Need and Licensure Board]~~ and issued a certificate of authority by the Department of Insurance as a health maintenance organization and which is qualified under the requirements of the United States Department of Health, Education and Welfare, except as provided in subsection (4) of this section.

(2) Cities of all classes, counties, and urban-county governments and the agencies of cities, counties, charter county, and urban-county governments are authorized to establish and operate plans for the payment of retirement, disability, health maintenance organization coverage, or hospitalization benefits to their employees and elected officers, and health maintenance organization coverage or hospitalization benefits to the immediate families of their employees and elected officers. The plan may require employees to pay a percentage of their salaries into a fund from which coverage or benefits are paid, or the city, county, charter county, urban-county government, or agency may pay out of its own funds the entire cost of the coverage or benefits. A plan may include a combination of contributions by employees and elected officers and by the city, county, charter county, urban-county government, or agency into a fund from which coverage or benefits are paid, or it may take any form desired by the city, county, charter county, urban-county government, or agency. Each city, county, charter county, urban-county government, or agency may make rules and regulations and do all other things necessary in the establishment and operation of the plan.

(3) Cities of all classes, counties, charter counties, urban-county governments, the agencies of cities, counties, charter counties, and urban-county governments, and all other political subdivisions of the state may provide disability, hospitalization, or other health or medical care coverage to their officers and employees, including their elected officers, through independent or cooperative self-insurance programs and may cooperatively purchase the coverages.

(4) Any city, county, charter county, or urban-county government which is a contributing member to any one (1) of the retirement systems administered by the state may participate in the state health insurance coverage program for state employees as defined in KRS 18A.225 to 18A.229. Should any city, county, charter county, or urban-county government opt at any time to participate in the state health insurance coverage program, it shall do so for a minimum of three (3) consecutive years. If after the three (3) year participation period, the city, county, charter county, or urban-county government chooses to terminate participation in the state health insurance coverage program, it will be excluded from further participation for a period of three (3) consecutive years. If a city, county, charter county, or urban-county government, or one (1) of its agencies, terminates participation of its active employees in the state health insurance coverage program and there is a state appropriation for the employer's contribution for active employees' health insurance coverage, neither the unit of government, or its agency, nor the employees shall receive the state-funded contribution after termination from the state employee health insurance program. The three (3) year participation and exclusion cycles shall take effect each time a city, county, charter county, or urban-county government changes its participation status.

(5) Any city, county, charter county, urban-county government, or other political subdivision of the state which employs more than twenty-five (25) persons and which provides hospitalization benefits or health maintenance organization coverage to its employees and elected officers, shall annually give its employees an option to elect either standard hospitalization benefits or membership in a qualified health maintenance organization which is engaged in providing basic health services in a health maintenance service area in which at least twenty-five (25) of the employees reside; except that if any city, county, charter county, urban-county government, or agencies of any city, county, charter county, urban-county

government, or any other political subdivision of the state which does not have a qualified health maintenance organization engaged in providing basic health services in a health maintenance service area in which at least twenty-five (25) of the employees reside, the city, county, charter county, urban-county government, or agencies of the city, county, charter county, urban-county government, or any other political subdivision of the state may annually give its employees an option to elect either standard hospitalization benefits or membership in a health maintenance organization which has been licensed by the ***Cabinet for Health and Family Services***~~[Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~ and issued a certificate of authority by the Department of Insurance as a health maintenance organization and which is engaged in providing basic health services in a health maintenance service area in which at least twenty-five (25) of the employees reside. Any premium due for health maintenance organization coverage over the amount contributed by the city, county, charter county, urban-county government, or other political subdivision of the state which employs more than twenty-five (25) persons for any other hospitalization benefit shall be paid by the employee.

(6) If an employee moves his place of residence or employment out of the service area of a health maintenance organization, under which he has elected coverage, into either the service area of another health maintenance organization or into an area of the state not within a health maintenance organization service area, the employee shall be given an option, at the time of the move or transfer, to elect coverage either by the health maintenance organization into which service area he moves or is transferred or to elect standard hospitalization coverage offered by the employer.

(7) Any plan adopted shall provide that any officer or member of a paid fire or police department who has completed five (5) years or more as a member of the department, but who is unable to perform his duties by reason of heart disease or

any disease of the lungs or respiratory tract, is presumed to have contracted his disease while on active duty as a result of strain or the inhalation of noxious fumes, poison or gases, and shall be retired by the pension board under terms of the pension system of which he is a member, if the member passed an entrance physical examination and was found to be in good health as required.

(8) The term "agency" as used herein shall include boards appointed to operate waterworks, electric plants, hospitals, airports, housing projects, golf courses, parks, health departments, or any other public project.

(9) After August 1, 1988, except as permitted by KRS 65.156, no new retirement plan shall be created pursuant to this section, and cities which were covered by this section on or prior to August 1, 1988, shall participate in the County Employees Retirement System effective August 1, 1988. Any city, county, charter county, urban-county, or agency thereof which provided a retirement plan for its employees, pursuant to this section, on or prior to August 1, 1988, shall place employees hired after August 1, 1988, in the County Employees Retirement System. The city, county, charter county, urban-county, or agency thereof shall offer employees hired on or prior to August 1, 1988, membership in the County Employees Retirement System under the alternate participation plan as described in KRS 78.530(3), but such employees may elect to retain coverage under this section.

➔Section 3. KRS 194A.010 is amended to read as follows:

(1) The cabinet is the primary state agency for operating the public health, Medicaid, ~~[certificate of need and]~~licensure, and mental health and intellectual disability programs in the Commonwealth. The function of the cabinet is to improve the health of all Kentuckians, including the delivery of population, preventive, reparative, and containment health services in a safe and effective fashion, and to improve the functional capabilities and opportunities of Kentuckians with disabilities. The cabinet is to accomplish its function through direct and contract

services for planning and ~~[through the state health plan and]~~departmental plans for program operations, for program monitoring and standard setting, and for program evaluation and resource management.

(2) The cabinet is the primary state agency responsible for leadership in protecting and promoting the well-being of Kentuckians through the delivery of quality human services. Recognizing that children are the Commonwealth's greatest natural resource and that individuals and their families are the most critical component of a strong society, the cabinet shall deliver social services to promote the safety and security of Kentuckians and preserve their dignity. The cabinet shall administer child welfare programs that promote collaboration and accountability among local, public, and private programs to improve the lives of families and children, including collaboration with the Council on Accreditation for Children and Family Services or its equivalent in developing strategies consistent with best practice standards for delivery of services. The cabinet also shall administer income-supplement programs that protect, develop, preserve, and maintain individuals, families, and children in the Commonwealth.

➔Section 4. KRS 194A.030 is amended to read as follows:

The cabinet consists of the following major organizational units, which are hereby created:

(1) Office of the Secretary. Within the Office of the Secretary, there shall be an Office of Communications and Administrative Review, an Office of Legal Services, an Office of Inspector General, an Office of the Ombudsman, and the Governor's Office of Electronic Health Information.

(a) The Office of Communications and Administrative Review shall include oversight of administrative hearings and communications with internal and external audiences of the cabinet. The Office of Communications and Administrative Review shall be headed by an executive director who shall be

appointed by the secretary with the approval of the Governor under KRS 12.050.

(b) The Office of Legal Services shall provide legal advice and assistance to all units of the cabinet in any legal action in which it may be involved. The Office of Legal Services shall employ all attorneys of the cabinet who serve the cabinet in the capacity of attorney, giving legal advice and opinions concerning the operation of all programs in the cabinet. The Office of Legal Services shall be headed by a general counsel who shall be appointed by the secretary with the approval of the Governor under KRS 12.050 and 12.210. The general counsel shall be the chief legal advisor to the secretary and shall be directly responsible to the secretary. The Attorney General, on the request of the secretary, may designate the general counsel as an assistant attorney general under the provisions of KRS 15.105.

(c) The Office of Inspector General shall be responsible for:

1. The conduct of audits and investigations for detecting the perpetration of fraud or abuse of any program by any client, or by any vendor of services with whom the cabinet has contracted; and the conduct of special investigations requested by the secretary, commissioners, or office heads of the cabinet into matters related to the cabinet or its programs;
2. Licensing and regulatory functions as the secretary may delegate;
3. Review of health facilities participating in transplant programs, as determined by the secretary, for the purpose of determining any violations of KRS 311.1911 to 311.1959, 311.1961, and 311.1963; and
4. The notification and forwarding of any information relevant to possible criminal violations to the appropriate prosecuting authority.

The Office of Inspector General shall be headed by an inspector general who

shall be appointed by the secretary with the approval of the Governor. The inspector general shall be directly responsible to the secretary.

(d) The Office of the Ombudsman shall provide professional support in the evaluation of programs, including but not limited to quality improvement and information analysis and reporting, contract monitoring, program monitoring, and the development of quality service delivery, and a review and resolution of citizen complaints about programs or services of the cabinet when those complaints are unable to be resolved through normal administrative remedies. The Office of the Ombudsman shall place an emphasis on research and best practice and program accountability and shall monitor federal compliance. The Office of the Ombudsman shall be headed by an executive director who shall be appointed by the secretary with the approval of the Governor in accordance with KRS 12.050.

(e) The Governor's Office of Electronic Health Information shall provide leadership in the redesign of the health care delivery system using electronic information technology as a means to improve patient care and reduce medical errors and duplicative services. The Governor's Office of Electronic Health Information shall be headed by an executive director who shall be appointed by the secretary with the approval of the Governor in accordance with KRS 12.050;

(2) Department for Medicaid Services. 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. The Department for Medicaid Services shall be headed by a commissioner for Medicaid services, who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for Medicaid services shall be a person who by experience and training in administration and management is qualified to perform the duties of this office. The

commissioner for Medicaid services shall exercise authority over the Department for Medicaid Services under the direction of the secretary and shall only fulfill those responsibilities as delegated by the secretary;

(3) Department for Public Health. The Department for Public Health shall develop and operate all programs of the cabinet that provide health services and all programs for assessing the health status of the population for the promotion of health and the prevention of disease, injury, disability, and premature death. This shall include but not be limited to oversight of the Division of Women's Health. The Department for Public Health shall be headed by a commissioner for public health who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for public health shall be a duly licensed physician who by experience and training in administration and management is qualified to perform the duties of this office. The commissioner shall advise the head of each major organizational unit enumerated in this section on policies, plans, and programs relating to all matters of public health, including any actions necessary to safeguard the health of the citizens of the Commonwealth. The commissioner shall serve as chief medical officer of the Commonwealth. The commissioner for public health shall exercise authority over the Department for Public Health under the direction of the secretary and shall only fulfill those responsibilities as delegated by the secretary;

(4) Department for Behavioral Health, Developmental and Intellectual Disabilities. The Department for Behavioral Health, Developmental and Intellectual Disabilities shall develop and administer programs for the prevention of mental illness, intellectual disabilities, brain injury, developmental disabilities, and substance abuse disorders and shall develop and administer an array of services and support for the treatment, habilitation, and rehabilitation of persons who have a mental illness or emotional disability, or who have an intellectual disability, brain injury, developmental

disability, or a substance abuse disorder. The Department for Behavioral Health, Developmental and Intellectual Disabilities shall be headed by a commissioner for behavioral health, developmental and intellectual disabilities who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for behavioral health, developmental and intellectual disabilities shall be by training and experience in administration and management qualified to perform the duties of the office. The commissioner for behavioral health, developmental and intellectual disabilities shall exercise authority over the department under the direction of the secretary, and shall only fulfill those responsibilities as delegated by the secretary;

(5) Commission for Children with Special Health Care Needs. The duties, responsibilities, and authority set out in KRS 200.460 to 200.490 shall be performed by the commission. The commission shall advocate the rights of children with disabilities and, to the extent that funds are available, shall ensure the administration of services for children with disabilities as are deemed appropriate by the commission pursuant to Title V of the Social Security Act. The commission may promulgate administrative regulations under KRS Chapter 13A as may be necessary to implement and administer its responsibilities. The duties, responsibilities, and authority of the Commission for Children with Special Health Care Needs shall be performed through the office of the executive director. The executive director shall be appointed by the secretary with the approval of the Governor under KRS 12.050;

(6) Office of Health Policy. The Office of Health Policy shall lead efforts to coordinate health care policy, including Medicaid, behavioral health, developmental and intellectual disabilities, mental health services, services for individuals with an intellectual disability, public health, ~~[certificate of need,]~~and health insurance. The duties, responsibilities, and authority pertaining to the ~~[certificate of need functions~~

~~and the ~~licensure appeal functions, as set out in KRS Chapter 216B, shall be performed by this office. The Office of Health Policy shall be headed by an executive director who shall be appointed by the secretary with the approval of the Governor pursuant to KRS 12.050;

(7) Department for Family Resource Centers and Volunteer Services. The Department for Family Resource Centers and Volunteer Services shall streamline the various responsibilities associated with the human services programs for which the cabinet is responsible. This shall include~~[,]~~ but not be limited to~~[,]~~ oversight of the Division of Family Resource and Youth Services Centers and the Kentucky Commission on Community Volunteerism and Services. The Department for Family Resource Centers and Volunteer Services shall be headed by a commissioner who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The commissioner for family resource centers and volunteer services shall be by training and experience in administration and management qualified to perform the duties of the office, shall exercise authority over the department under the direction of the secretary, and shall only fulfill those responsibilities as delegated by the secretary;

(8) Office of Administrative and Technology Services. The Office of Administrative and Technology Services shall develop and maintain technology, technology infrastructure, and information management systems in support of all units of the cabinet. The office shall have responsibility for properties and facilities owned, maintained, or managed by the cabinet. The Office of Administrative and Technology Services shall be headed by an executive director who shall be appointed by the secretary with the approval of the Governor under KRS 12.050. The executive director shall exercise authority over the Office of Administrative and Technology Services under the direction of the secretary and shall only fulfill those responsibilities as delegated by the secretary;

(9) Office of Human Resource Management. The Office of Human Resource Management shall coordinate, oversee, and execute all personnel, training, and management functions of the cabinet. The office shall focus on the oversight, development, and implementation of quality personnel services; curriculum development and delivery of instruction to staff; the administration, management, and oversight of training operations; health, safety, and compliance training; and equal employment opportunity compliance functions. The office shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050;

(10) The Office of Finance and Budget shall provide central review and oversight of budget, contracts, and cabinet finances. The office shall provide coordination, assistance, and support to program departments and independent review and analysis on behalf of the secretary. The office shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050;

(11) Department for Community Based Services. The Department for Community Based Services shall administer and be responsible for child and adult protection, violence prevention resources, foster care and adoption, permanency, and services to enhance family self-sufficiency, including child care, social services, public assistance, and family support. The department shall be headed by a commissioner appointed by the secretary with the approval of the Governor in accordance with KRS 12.050;

(12) Department for Income Support. The Department for Income Support shall be responsible for child support enforcement and disability determination. The department shall serve as the state unit as required by Title II and Title XVI of the Social Security Act, and shall have responsibility for determining eligibility for disability for those citizens of the Commonwealth who file applications for disability with the Social Security Administration. The department shall be headed

by a commissioner appointed by the secretary with the approval of the Governor in accordance with KRS 12.050;

(13) Department for Aging and Independent Living. The Department for Aging and Independent Living shall serve as the state unit as designated by the Administration on Aging Services under the Older Americans Act and shall have responsibility for administration of the federal community support services, in-home services, meals, family and caregiver support services, elder rights and legal assistance, senior community services employment program, the state health insurance assistance program, state home and community based services including home care, Alzheimer's respite services and the personal care attendant program, certifications of adult day care and assisted living facilities, the state Council on Alzheimer's Disease and other related disorders, the Institute on Aging, and guardianship services. The department shall also administer the Long-Term Care Ombudsman Program and the Medicaid Home and Community Based Waivers Consumer Directed Option (CDO) Program. The department shall serve as the information and assistance center for aging and disability services and administer multiple federal grants and other state initiatives. The department shall be headed by a commissioner appointed by the secretary with the approval of the Governor in accordance with KRS 12.050; and

(14) The Office of Legislative and Regulatory Affairs shall provide central review and oversight of legislation, policy, and administrative regulations. The office shall provide coordination, assistance, and support to program departments and independent review and analysis on behalf of the secretary. The office shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050.

➔Section 5. KRS 194A.090 is amended to read as follows:

(1) The cabinet shall include citizen advisory bodies within its structure to provide

independent advice from the general public.

(2) A Public Health Services Advisory Council is created within the cabinet.

(a) The council may advise the secretary for health and family services, the commissioner for public health, and officials of the Commonwealth on policy matters concerning the delivery of health services, including the assessment of needs, the development of program alternatives, the determination of priorities, the formulation of policy, the allocation of resources, and the evaluation of programs. The council shall be utilized by the cabinet to fulfill federal requirements for citizen's advisory councils associated with programs designed to provide health services~~[and to advise the cabinet on the development and content of the state health plan]~~.

(b) The council shall be composed of no more than nineteen (19) citizen members appointed by the Governor. Six (6) members of the council shall be chosen to broadly represent public interest groups concerned with health services, recipients of health services provided by the Commonwealth, minority groups, and the general public. Thirteen (13) members of the council shall represent providers of health care and not less than one-half (1/2) of the providers shall be direct providers of health care. At least one (1) of the direct providers of health care shall be a person engaged in the administration of a hospital, and one (1) shall be a physician in active practice. At least one (1) member shall be a registered sanitarian or sanitary engineer, one (1) a public health nurse, one (1) a member of the current minority advisory council, and one (1) a practicing public health physician. Nominations for health care provider members of the council shall be solicited from recognized health care provider organizations. Membership of the council shall be geographically distributed in order that area development districts are represented. Members shall serve for terms of three (3) years. If a vacancy occurs, the person appointed as a

replacement shall serve only for the remainder of the vacated term. Members shall serve until the term begins for their appointed successors. No member shall serve more than two (2) consecutive terms. The chair of the council shall be appointed by the Governor. The secretary for health and family services and the commissioner for public health shall be nonvoting, ex officio members of the council, and the commissioner for public health shall be a staff director for, and secretary to, the council. The council shall meet at least quarterly and on other occasions as may be necessary on the call of the secretary for health and family services or the commissioner for public health. A majority of the appointed members shall constitute a quorum.

(3) An Institute for Aging is created within the cabinet.

(a) The institute shall advise the secretary for health and family services and other officials of the Commonwealth on policy matters relating to the development and delivery of services to the aged.

(b) The institute shall be composed of no more than fifteen (15) citizen members appointed by the Governor. Members of the institute shall be chosen to broadly represent public interest groups concerned with the needs of the aged, professionals involved in the delivery of services to the aged, minority groups, recipients of state-provided services to the aged, and the general public. The Governor shall appoint a chair of the institute. The secretary for health and family services shall be a nonvoting, ex officio member of, staff director for, and secretary to the institute. The institute shall meet at least quarterly and on other occasions as may be necessary, on the call of the secretary for health and family services. A majority of the appointed members shall constitute a quorum.

➔Section 6. KRS 211.192 is amended to read as follows:

(1) For the purposes of this section:

(a) "Down syndrome" means a chromosomal condition caused by cell division that results in the presence of an extra whole or partial copy of chromosome 21; and

(b) "Spina bifida" means a neural tube defect, the most common of which is the open neural tube defect myelomeningocele.

(2) A health facility as defined in KRS 216B.015~~[(13)]~~, physician, health care provider, nurse midwife, or genetic counselor who renders prenatal care, postnatal care, or genetic counseling, upon receipt of a positive test result from a test for Down syndrome or spina bifida, shall provide the expectant or new parent with information provided by the Cabinet for Health and Family Services under subsection (3) of this section.

(3) The Cabinet for Health and Family Services shall make available to any person who renders prenatal care, postnatal care, or genetic counseling to parents who receive a prenatal or postnatal diagnosis of Down syndrome or spina bifida and to any person who has received a positive test result from a test for Down syndrome or spina bifida the following:

(a) Up-to-date, evidence-based, written information about Down syndrome or spina bifida that has been reviewed by medical experts and Down syndrome or spina bifida organizations and includes information on physical, developmental, educational, and psychosocial outcomes, life expectancy, clinical course, intellectual and functional development, and treatment options; and

(b) Contact information regarding support programs and services for expectant and new parents of children with Down syndrome or spina bifida, including information hotlines specific to Down syndrome or spina bifida, resource centers or clearinghouses, national and local Down syndrome or spina bifida organizations such as Down Syndrome of Louisville, Down Syndrome

Association of Central Kentucky, Down Syndrome Association of South Central Kentucky, Green River Area Down Syndrome Association, Down Syndrome Association of Greater Cincinnati Serving Northern Kentucky, Council on Developmental Disabilities, the Spina Bifida Association of Kentucky, and other education and support programs.

➔Section 7. KRS 205.634 is amended to read as follows:

(1) ~~[No medical assistance payments shall be made under this chapter to any out-of-state health facility or health service providing services within the geographic boundaries of the Commonwealth who does not have a certificate of need if the health facility or health service would be required to obtain a certificate of need under KRS Chapter 216B if the facility or service were located within the geographic boundaries of the Commonwealth.~~

~~(2) ~~]The Department for Medicaid Services and the Department for Community Based Services shall not reimburse an out-of-state provider of residential care for children whose care is paid by state general funds or state administered federal funds, unless the Department for Medicaid Services or the Department for Community Based Services or a designated agent thereof has determined that there is no provider within the Commonwealth that is capable and willing to provide comparable services at a comparable cost per child to those that would be delivered by the out-of-state provider. An exception may be made if:

(a) The identified in-state resource is farther away from the child's parent or guardian than a similar out-of-state resource; or

(b) The services offered by the out-of-state resource is deemed by either department or a designated agent thereof to be more appropriate for the individual child than the services offered by the in-state provider.

(2)~~[(3)]~~ Prior to promulgating administrative regulations governing the determination of the availability of providers of residential care within the Commonwealth, the

Department for Medicaid Services and the Department for Community Based Services shall establish uniform conditions, requirements, and exceptions for the determination of the availability of providers of residential care within the Commonwealth.

(3) ~~[(4)]~~ Each department shall promulgate an administrative regulation in accordance with KRS Chapter 13A that contains the uniform conditions, requirements, and exceptions for the determination of the availability of providers of residential care within the Commonwealth established under subsection (3) of this section.

➔Section 8. KRS 216.361 is amended to read as follows:

Notwithstanding any provision of law to the contrary, hospitals located in a hospital district pursuant to KRS 216.310 to 216.360 may offer the following services and facilities in counties contiguous to the hospital district~~[and shall obtain a certificate of need where required]~~:

(1) Home health services;

(2) Rural health clinics;

(3) Physician office buildings;

(4) Mobile diagnostic services; and

(5) Any other service or facility where there is agreement between the hospital and a provider located in a county contiguous to the hospital district to jointly develop and operate the service or facility.

➔Section 9. KRS 216.380 is amended to read as follows:

(1) The licensure category of critical access hospital is hereby created for existing licensed acute-care hospitals which qualify under this section for that status.

(2) It shall be unlawful to operate or maintain a critical access hospital without first obtaining a license from the Cabinet for Health and Family Services.~~[An acute-care hospital converting to a critical access hospital shall not require a certificate of need. A certificate of need shall not be required for services provided on a~~

~~contractual basis in a critical access hospital. A certificate of need shall not be required for an existing critical access hospital to increase its acute-care bed capacity to twenty-five (25) beds.]~~

(3) Except as provided in subsection (4) of this section, only a hospital licensed as a general acute-care hospital may be relicensed as a critical access hospital if:

(a) The hospital is located in a county in a rural area that is:

1. Located more than a thirty-five (35) mile drive, or, where the terrain is mountainous or only secondary roads are available, located more than a fifteen (15) mile drive, from another acute-care hospital or critical access hospital; or

2. Certified by the secretary as a necessary provider of health care services to area residents;

(b) For the purposes of paragraph (a) of this subsection, a hospital shall be considered to be located in a rural area if the hospital is not in a county which is part of a standard metropolitan statistical area, the hospital is located in a rural census tract of a metropolitan statistical area as determined under the most recent modification of the Goldsmith Modification, or is designated by the state as a rural provider. The secretary shall designate a hospital as a rural provider if the hospital is not located in a county which has the largest county population of a standard metropolitan statistical area;

(c) Except as provided in paragraph (d) of this subsection, the hospital provides not more than twenty-five (25) acute care inpatient beds for providing acute inpatient care for a period that does not exceed, as determined on an annual, average basis, ninety-six (96) hours;

(d) If the hospital is operating swing beds under which the hospital's inpatient hospital facilities are used for the provision of extended care services, the hospital may be designated as a critical access hospital so long as the total

number of beds that may be used at any time for furnishing of either extended care services or acute inpatient services does not exceed twenty-five (25) beds. For the purposes of this section, any bed of a unit of the hospital that is licensed as a nursing facility at the time the hospital applies to the state for designation as a critical care access hospital shall not be counted.

(4) The secretary for health and family services may designate a facility as a critical access hospital if the facility:

(a) Was a hospital that ceased operations on or after ten (10) years prior to April 21, 2000; or

(b) Was a hospital that was converted to a licensed primary care center, rural health clinic, ambulatory health center, or other type of licensed health clinic or health center and, as of the effective date of that conversion, meets the criteria for licensure as a critical access hospital under this subsection or subsection (3) of this section.

(5) A critical access hospital shall provide the following services:

(a) Twenty-four (24) hour emergency-room care that the secretary determines is necessary for insuring access to emergency care services in each area served by a critical access hospital; and

(b) Basic laboratory, radiologic, pharmacy, and dietary services. These services may be provided on a part-time, off-site contractual basis.

(6) A critical access hospital may provide the following services:

(a) Swing beds or a distinct unit of the hospital which is a nursing facility in accordance with KRS Chapter 216B~~[and subject to approval under certificate of need]~~;

(b) Surgery;

(c) Normal obstetrics;

(d) Primary care;

(e) Adult day health care;

(f) Respite care;

(g) Rehabilitative and therapeutic services**,** including~~[,]~~ but not limited to~~[,]~~ physical therapy, respiratory therapy, occupational therapy, speech pathology, and audiology, which may be provided on an off-site contractual basis;

(h) Ambulatory care;

(i) Home health services~~[which may be established upon obtaining a certificate of need]~~; and

(j) Mobile diagnostic services with equipment not exceeding the major medical equipment cost threshold pursuant to KRS Chapter 216B~~[and for which there are no review criteria in the State Health Plan]~~.

(7) In addition to the services that may be provided under subsection (6) of this section, a critical access hospital may establish the following units in accordance with applicable Medicare regulations~~[and subject to certificate of need approval]~~:

(a) A psychiatric unit that is a distinct part of the hospital, with a maximum of ten (10) beds; and

(b) A rehabilitation unit that is a distinct part of the hospital, with a maximum of ten (10) beds notwithstanding any other bed limit contained in law or regulation.

(8) Psychiatric unit and rehabilitation unit beds operated under subsection (7) of this section shall not be counted in determining the number of beds or the average length of stay of a critical access hospital for purposes of applying the bed and average length of stay limitations under paragraph (c) of subsection (3) of this section.

(9) The following staffing plan shall apply to a critical access hospital:

(a) The hospital shall meet staffing requirements as would apply under section 1861(e) of Title XVIII of the Federal Social Security Act to a hospital located

in a rural area except that:

1. The hospital need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the hospital shall be open and fully staffed, except insofar as the facility is required to make available emergency services and nursing services available on a twenty-four (24) hour basis; and

2. The hospital need not otherwise staff the facility except when an inpatient is present; and

(b) Physician assistants and nurse practitioners may provide inpatient care within the limits of their statutory scope of practice and with oversight by a physician who is not required to be on-site at the hospital.

(10) A critical access hospital shall have a quality assessment and performance improvement program and procedures for review of utilization of services.

(11) A critical access hospital shall have written contracts assuring the following linkages:

(a) Secondary and tertiary hospital referral services which shall provide for the transfer of a patient to the appropriate level of care and the transfer of patients to the critical access hospital for recuperative care;

(b) Ambulance services;

(c) Home health services; and

(d) Nursing facility services if not provided on-site.

(12) If the critical access hospital is part of a rural health network, the hospital shall have the following:

(a) An agreement for patient referral and transfer, development, and use of communications systems including telemetry and electronic sharing of patient data, and emergency and nonemergency transportation; and

(b) An agreement for credentialing and quality assurance with a network hospital,

peer review organization, or other appropriate and qualified entity identified in the state rural health plan.

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

(14) The Cabinet for Health and Family Services shall promulgate administrative regulations pursuant to KRS Chapter 13A necessary to implement this section.

➔Section 10. KRS 216.560 is amended to read as follows:

(1) If a licensee has failed to correct a Type A violation within the time specified for correction by the cabinet, the cabinet shall assess the licensee a civil penalty in the amount of five hundred dollars ($500) for each day that the deficiency continues beyond the date specified for correction. Application for an extension of time, not to exceed ten (10) days, may be granted by the cabinet upon a showing by the licensee that adequate arrangements have been made to protect the health and safety of the residents. A facility that is assessed a civil monetary penalty in accordance with applicable federal laws and regulations under Title 18 or 19 of the Federal Social Security Act shall not be subject to the civil monetary penalty established in this subsection for the same violation.

(2) If a licensee has failed to correct a Type B violation within the time specified for correction by the cabinet, the cabinet shall assess the licensee a civil penalty in the amount of two hundred dollars ($200) for each day that the deficiency continues beyond the date specified for correction. Application for an extension of time, not to exceed (10) days, may be granted by the cabinet upon a showing by the licensee that

adequate arrangements have been made to protect the health and safety of the residents. A facility that is assessed a civil monetary penalty in accordance with applicable federal laws and regulations under Title 18 or 19 of the Federal Social Security Act shall not be subject to the civil monetary penalty established in this subsection for the same violation.

(3) The civil penalties authorized by KRS 216.537 to 216.590 shall be trebled when a licensee has received a citation for violating a statute or regulation for which it has received a citation during the previous twelve (12) months.

(4) Payment of penalties shall not be made from moneys used for direct patient care nor shall the payment of penalties be a reimbursable cost under Medicaid or Medicare.

(5) KRS 216B.990***(2)*** ~~[(3)]~~ shall not apply to the offenses defined herein.

(6) A personal care home that is assessed a civil monetary penalty for a Type A or Type B citation shall have the amount of the penalty reduced by the dollar amount that the facility can verify was used to correct the deficiency, if:

(a) The condition resulting in the deficiency citation existed for less than thirty (30) days prior to the date of the citation; or

(b) The facility has not intentionally delayed correcting the deficiency to secure a reduction in a penalty that might subsequently be assessed.

(7) All administrative fines collected by the cabinet pursuant to KRS 216.537 to 216.590 shall be deposited in the Kentucky nursing incentive scholarship fund, which is hereby created, and the balance of that fund shall not lapse at the end of the fiscal year to the general fund.

➔Section 11. KRS 216.577 is amended to read as follows:

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

therefor:

(1) Institute proceedings to obtain an order compelling compliance with the regulations, standards, or requirements as set forth by the ***Cabinet for Health and Family Services***~~[Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~, the provisions of KRS 216.510 to 216.525, or applicable federal laws and regulations governing the certification of a long-term care facility under Title 18 or 19 of the Social Security Act;

(2) Institute injunctive proceedings in Circuit Court to terminate the operation of the facility; or

(3) Selectively transfer residents whose care needs are not being adequately met by the long-term care facility.

➔Section 12. KRS 216.595 is amended to read as follows:

(1) (a) Any assisted-living community as defined by KRS 194A.700, long-term care facility as defined in KRS 216.535~~[, or long-term care facility constructed under KRS 216B.071]~~ that claims to provide special care for persons with a medical diagnosis of Alzheimer's disease or other brain disorders shall maintain a written and current manual that contains the information specified in subsection (2) of this section. This manual shall be maintained in the office of the community's or facility's director and shall be made available for inspection upon request of any person. The community or facility shall make a copy of any program or service information contained in the manual for a person who requests information about programs or services, at no cost to the person making the request.

(b) Any advertisement of the community or facility shall contain the following statement: "Written information relating to this community's or facility's services and policies is available upon request."

(c) The community or facility shall post a statement in its entrance or lobby as

follows: "Written information relating to this community's or facility's services and policies is available upon request."

(2) The community or facility shall maintain and update written information on the following:

(a) The assisted-living community's or long-term care facility's mission or philosophy statement concerning the needs of residents with Alzheimer's disease or other brain disorders;

(b) The process and criteria the assisted-living community or long-term care facility uses to determine placement into services for persons with Alzheimer's disease or other brain disorders;

(c) The process and criteria the assisted-living community or long-term care facility uses to transfer or discharge persons from special services for Alzheimer's or other brain disorders;

(d) The supervision provided for residents with a medical diagnosis of Alzheimer's disease or other brain disorders;

(e) The family's role in care;

(f) The process for assessing, planning, implementing, and evaluating the plan of care for persons with Alzheimer's disease or other brain disorders;

(g) A description of any special care services for persons with Alzheimer's disease or other brain disorders;

(h) Any costs associated with specialized services for Alzheimer's disease or other brain disorders; and

(i) A description of dementia or other brain disorder-specific staff training that is provided, including but not limited to the content of the training, the number of offered and required hours of training, the schedule for training, and the staff who are required to complete the training.

(3) An assisted-living community may request a waiver from the Cabinet for Health

and Family Services regarding building requirements to address the specialized needs of individuals with Alzheimer's disease or other brain disorders.

➔Section 13. KRS 216.885 is amended to read as follows:

(1) It is unlawful to operate or maintain a PPEC center without first obtaining a ~~[certificate of need and a]~~license for the PPEC center from the cabinet. The cabinet is responsible for licensing PPEC centers in accordance with the provisions of KRS Chapter 216B.

(2) Separate licenses are required for PPEC centers maintained on separate premises, even though they are operated under the same management. Separate licenses are not required for separate buildings on the same grounds.

(3) The Cabinet for Health and Family Services may deny, revoke, modify, or suspend a license in accordance with KRS 216B.105.

➔Section 14. KRS 216.905 is amended to read as follows:

It shall be unlawful to operate or maintain a network without first obtaining a license from the Cabinet for Health and Family Services.~~[A network shall not require a certificate of need.]~~

➔Section 15. KRS 216.935 is amended to read as follows:

As used in KRS 216.935 to 216.939, unless the context requires otherwise:

(1) "Home health aide" means an individual who is hired to perform home health aide services.

(2) "Home health agency" means a public agency or private organization, or a subdivision of such an agency or organization which is licensed as a home health agency by the ***Cabinet for Health and Family Services***~~[Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~ and is certified to participate as a home health agency under Title XVIII of the Social Security Act.

(3) "Home health aide services" means those services provided by a home health aide and supervised by a registered nurse which are directed towards the personal care of

the patient. Such services shall include~~[,]~~ but not be limited to~~[,]~~ the following:

(a) Helping the patient with bath and care of mouth, skin, and hair;

(b) Helping the patient to the bathroom or in using a bedpan;

(c) Helping the patient in and out of bed and assisting with ambulation;

(d) Helping the patient with prescribed exercises which the patient and home health aide have been taught by appropriate professional personnel;

(e) Assisting with medication ordinarily self-administered that has been specifically ordered by a physician or advanced practice registered nurse;

(f) Performing incidental household services as are essential to the patient's health care at home, if these services would have been performed if the patient was in a hospital or skilled nursing facility; and

(g) Reporting changes in the patient's condition or family situation to the professional nurse supervisor.

(4) "Nurse aide" means an individual, including a nursing student, medication aide, and a person employed through a nursing pool, who provides nursing or nursing related services to a resident in a nursing facility or home health agency, excluding:

(a) An individual who is a licensed health professional;

(b) A volunteer who provides the nursing or nursing-related services without monetary compensation; and

(c) A person who is hired by the resident or family to sit with the resident and who does not perform nursing or nursing-related services.

➔Section 16. KRS 216B.015 is amended to read as follows:

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

(1) "Abortion facility" means any place in which an abortion is performed;

(2) "Administrative regulation" means a regulation adopted and promulgated pursuant to the procedures in KRS Chapter 13A;

(3) ~~["Affected persons" means the applicant; any person residing within the geographic area served or to be served by the applicant; any person who regularly uses health facilities within that geographic area; health facilities located in the health service area in which the project is proposed to be located which provide services similar to the services of the facility under review; health facilities which, prior to receipt by the agency of the proposal being reviewed, have formally indicated an intention to provide similar services in the future; and the cabinet and third-party payors who reimburse health facilities for services in the health service area in which the project is proposed to be located;~~

~~(4) ~~](a) "Ambulatory surgical center" means a health facility:

1. Licensed pursuant to administrative regulations promulgated by the cabinet;
2. That provides outpatient surgical services, excluding oral or dental procedures; and
3. Seeking recognition and reimbursement as an ambulatory surgical center from any federal, state, or third-party insurer from which payment is sought.

(b) An ambulatory surgical center does not include the private offices of physicians where in-office outpatient surgical procedures are performed as long as the physician office does not seek licensure, certification, reimbursement, or recognition as an ambulatory surgical center from a federal, state, or third-party insurer.

(c) Nothing in this subsection shall preclude a physician from negotiating enhanced payment for outpatient surgical procedures performed in the physician's private office so long as the physician does not seek recognition or reimbursement of his or her office as an ambulatory surgical center without first obtaining a ~~[certificate of need or]~~license required under KRS 216B.020~~[~~

~~and 216B.061]~~;

(4) ~~[(5)]~~ "Applicant" means any physician's office requesting a major medical equipment expenditure of one million five hundred thousand dollars ($1,500,000) or more after July 15, 1996, adjusted annually, or any person, health facility, or health service requesting a ~~[certificate of need or]~~license;

(5) ~~[(6)]~~ "Cabinet" means the Cabinet for Health and Family Services;

(6) ~~[(7)]~~ "Capital expenditure" means an expenditure made by or on behalf of a health facility which:

(a) Under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance or is not for investment purposes only; or

(b) Is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part thereof;

(7) ~~[(8)]~~ "Capital expenditure minimum" means one million five hundred thousand dollars ($1,500,000) beginning with July 15, 1994, and as adjusted annually thereafter. In determining whether an expenditure exceeds the expenditure minimum, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the improvement, expansion, or replacement of any plant or any equipment with respect to which the expenditure is made shall be included. Donations of equipment or facilities to a health facility which if acquired directly by the facility would be subject to review under this chapter shall be considered a capital expenditure, and a transfer of the equipment or facilities for less than fair market value shall be considered a capital expenditure if a transfer of the equipment or facilities at fair market value would be subject to review;

~~[(9) "Certificate of need" means an authorization by the cabinet to acquire, to establish, to offer, to substantially change the bed capacity, or to substantially change a health~~

~~service as covered by this chapter;~~

~~(10)~~***(8)*** "Certified surgical assistant" means a certified surgical assistant or certified first assistant who is certified by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants. The certified surgical assistant is an unlicensed health-care provider who is directly accountable to a physician licensed under KRS Chapter 311 or, in the absence of a physician, to a registered nurse licensed under KRS Chapter 314;

(9)~~[(11)]~~ "Continuing care retirement community" means a community that provides, on the same campus, a continuum of residential living options and support services to persons sixty (60) years of age or older under a written agreement. The residential living options shall include independent living units, nursing home beds, and either assisted living units or personal care beds;

~~([12) "Formal review process" means the ninety (90) day certificate-of-need review conducted by the cabinet;]~~

(10)~~[(13)]~~ "Health facility" means any institution, place, building, agency, or portion thereof, public or private, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, nursing, rehabilitative, or preventive care and includes alcohol abuse, drug abuse, and mental health services. This shall include but shall not be limited to health facilities and health services commonly referred to as hospitals, psychiatric hospitals, physical rehabilitation hospitals, chemical dependency programs, tuberculosis hospitals, skilled nursing facilities, nursing facilities, nursing homes, personal care homes, intermediate care facilities, family care homes, primary care centers, rural health clinics, outpatient clinics, ambulatory care facilities, ambulatory surgical centers, emergency care centers and services, ambulance providers, hospices, community centers for mental health or individuals with an intellectual disability, home health agencies, kidney

disease treatment centers and freestanding hemodialysis units, facilities and services owned and operated by health maintenance organizations directly providing health services ~~[subject to certificate of need]~~, and others providing similarly organized services regardless of nomenclature;

(11) ~~[(14]~~) "Health services" means clinically related services provided within the Commonwealth to two (2) or more persons, including but not limited to diagnostic, treatment, or rehabilitative services, and includes alcohol, drug abuse, and mental health services;

(12) ~~[(15)]~~ "Independent living" means the provision of living units and supportive services, including but not limited to laundry, housekeeping, maintenance, activity direction, security, dining options, and transportation;

(13) ~~[(16)]~~ "Intraoperative surgical care" includes the practice of surgical assisting in which the certified surgical assistant or physician assistant is working under the direction of the operating physician as a first or second assist, and which may include the following procedures:

(a) Positioning the patient;

(b) Preparing and draping the patient for the operative procedure;

(c) Observing the operative site during the operative procedure;

(d) Providing the best possible exposure of the anatomy incident to the operative procedure;

(e) Assisting in closure of incisions and wound dressings; and

(f) Performing any task, within the role of an unlicensed assistive person, or if the assistant is a physician assistant, performing any task within the role of a physician assistant, as required by the operating physician incident to the particular procedure being performed;

(14) ~~[(17)]~~ "Major medical equipment" means equipment which is used for the provision of medical and other health services and which costs in excess of the medical

equipment expenditure minimum. For purposes of this subsection, "medical equipment expenditure minimum" means one million five hundred thousand dollars ($1,500,000) beginning with July 15, 1994, and as adjusted annually thereafter. In determining whether medical equipment has a value in excess of the medical equipment expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of the equipment shall be included;

~~[(18) "Nonsubstantive review" means an expedited review conducted by the cabinet of an application for a certificate of need as authorized under KRS 216B.095;~~

~~(19)]~~***(15)*** "Nonclinically related expenditures" means expenditures for:

(a) Repairs, renovations, alterations, and improvements to the physical plant of a health facility which do not result in a substantial change in beds, a substantial change in a health service, or the addition of major medical equipment, and do not constitute the replacement or relocation of a health facility; or

(b) Projects which do not involve the provision of direct clinical patient care, including but not limited to the following:

1. Parking facilities;
2. Telecommunications or telephone systems;
3. Management information systems;
4. Ventilation systems;
5. Heating or air conditioning, or both;
6. Energy conservation; or
7. Administrative offices;

~~[(20) "Party to the proceedings" means the applicant for a certificate of need and any affected person who appears at a hearing on the matter under consideration and enters an appearance of record;]~~

(16)~~[(21)]~~ "Perioperative nursing" means a practice of nursing in which the nurse

provides preoperative, intraoperative, and postoperative nursing care to surgical patients;

(17) ~~[(22)]~~ "Person" means an individual, a trust or estate, a partnership, a corporation, an association, a group, state, or political subdivision or instrumentality including a municipal corporation of a state;

(18) ~~[(23)]~~ "Physician assistant" means the same as the definition provided in KRS 311.550;

(19) ~~[(24)]~~ "Record" means, as applicable in a particular proceeding:

(a) The application and any information provided by the applicant at the request of the cabinet;

(b) Any information provided by a holder of a ~~[certificate of need or]~~license in response to a notice of revocation of a ~~[certificate of need or]~~license;

(c) Any memoranda or documents prepared by or for the cabinet regarding the matter under review which were introduced at any hearing;

(d) Any staff reports or recommendations prepared by or for the cabinet;

(e) Any recommendation or decision of the cabinet;

(f) Any testimony or documentary evidence adduced at a hearing;

(g) The findings of fact and opinions of the cabinet or the findings of fact and recommendation of the hearing officer; and

(h) Any other items required by administrative regulations promulgated by the cabinet;

(20) ~~[(25)]~~ "Registered nurse first assistant" means one who:

(a) Holds a current active registered nurse licensure;

(b) Is certified in perioperative nursing; and

(c) Has successfully completed and holds a degree or certificate from a recognized program, which shall consist of:

1. The Association of Operating Room Nurses, Inc., Core Curriculum for

the registered nurse first assistant; and

2. One (1) year of postbasic nursing study, which shall include at least forty-five (45) hours of didactic instruction and one hundred twenty (120) hours of clinical internship or its equivalent of two (2) college semesters.

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

(21) ~~[(26)]~~ "Secretary" means the secretary of the Cabinet for Health and Family Services;

(22) ~~[(27)]~~ "Sexual assault examination facility" means a licensed health facility, emergency medical facility, primary care center, or a children's advocacy center or rape crisis center that is regulated by the Cabinet for Health and Family Services, and that provides sexual assault examinations under KRS 216B.400;

~~[(28) "State health plan" means the document prepared triennially, updated annually, and approved by the Governor;]~~

(23) ~~[(29)]~~ "Substantial change in a health service" means:

(a) ~~[The addition of a health service for which there are review criteria and standards in the state health plan;~~

~~(b)]~~The addition of a health service subject to licensure under this chapter; or

(c) The reduction or termination of a health service which had previously been provided in the health facility;

(24) ~~[(30)]~~ "Substantial change in bed capacity" means the addition, reduction, relocation, or redistribution of beds by licensure classification within a health facility;

(25) ~~[(31)]~~ "Substantial change in a project" means a change made to a pending or approved project which results in:

(a) A substantial change in a health service, except a reduction or termination of a

health service;

(b) A substantial change in bed capacity, except for reductions;

(c) A change of location; or

(d) An increase in costs greater than the allowable amount as prescribed by regulation;

(26) ~~[(32)]~~ "To acquire" means to obtain from another by purchase, transfer, lease, or other comparable arrangement of the controlling interest of a capital asset or capital stock, or voting rights of a corporation. An acquisition shall be deemed to occur when more than fifty percent (50%) of an existing capital asset or capital stock or voting rights of a corporation is purchased, transferred, leased, or acquired by comparable arrangement by one (1) person from another person;

~~[(33) "To batch" means to review in the same review cycle and, if applicable, give comparative consideration to all filed applications pertaining to similar types of services, facilities, or equipment affecting the same health service area;]~~

(27) ~~[(34)]~~ "To establish" means to construct, develop, or initiate a health facility;

(28) ~~[(35)]~~ "To obligate" means to enter any enforceable contract for the construction, acquisition, lease, or financing of a capital asset. A contract shall be considered enforceable when all contingencies and conditions in the contract have been met. An option to purchase or lease which is not binding shall not be considered an enforceable contract; and

(29) ~~[(36)]~~ "To offer" means, when used in connection with health services, to hold a health facility out as capable of providing, or as having the means of providing, specified health services.

➔Section 17. KRS 216B.020 is amended to read as follows:

(1) ~~[The provisions of this chapter that relate to the issuance of a certificate of need shall not apply to abortion facilities as defined in KRS 216B.015; any hospital which does not charge its patients for hospital services and does not seek or accept~~

~~Medicare, Medicaid, or other financial support from the federal government or any state government; assisted living residences; family care homes; state veterans' nursing homes; services provided on a contractual basis in a rural primary care hospital as provided under KRS 216.380; community mental health centers for services as defined in KRS Chapter 210; primary care centers; rural health clinics; private duty nursing services licensed as nursing pools; group homes; licensed residential crisis stabilization units, which may be part of a licensed psychiatric hospital; licensed free-standing residential substance use disorder treatment programs with sixteen (16) or fewer beds, but not including Levels I and II psychiatric residential treatment facilities or licensed psychiatric inpatient beds; outpatient behavioral health treatment, but not including partial hospitalization programs; end stage renal disease dialysis facilities, freestanding or hospital based; swing beds; special clinics, including but not limited to wellness, weight loss, family planning, disability determination, speech and hearing, counseling, pulmonary care, and other clinics which only provide diagnostic services with equipment not exceeding the major medical equipment cost threshold and for which there are no review criteria in the state health plan; nonclinically related expenditures; nursing home beds that shall be exclusively limited to on-campus residents of a certified continuing care retirement community; home health services provided by a continuing care retirement community to its on-campus residents; the relocation of hospital administrative or outpatient services into medical office buildings which are on or contiguous to the premises of the hospital; residential hospice facilities established by licensed hospice programs; or the following health services provided on site in an existing health facility when the cost is less than six hundred thousand dollars ($600,000) and the services are in place by December 30, 1991: psychiatric care where chemical dependency services are provided, level one (1) and level two (2) of neonatal care, cardiac catheterization, and open heart~~

~~surgery where cardiac catheterization services are in place as of July 15, 1990. The provisions of this section shall not apply to nursing homes, personal care homes, intermediate care facilities, and family care homes; or nonconforming ambulance services as defined by administrative regulation. These listed facilities or services shall be subject to licensure, when applicable.~~

~~(2) [~~Nothing in this chapter shall be construed to authorize the licensure, supervision, regulation, or control in any manner of:

(a) Private offices and clinics of physicians, dentists, and other practitioners of the healing arts, except any physician's office that meets the criteria set forth in KRS 216B.015~~[(5)]~~ or that meets the definition of an ambulatory surgical center as set out in KRS 216B.015;

(b) Office buildings built by or on behalf of a health facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts; unless the physician's office meets the criteria set forth in KRS 216B.015~~[(5)]~~, or unless the physician's office is also an abortion facility as defined in KRS 216B.015, except no capital expenditure or expenses relating to any such building shall be chargeable to or reimbursable as a cost for providing inpatient services offered by a health facility;

(c) Dispensaries and first-aid stations located within business or industrial establishments maintained solely for the use of employees, if the facility does not contain inpatient or resident beds for patients or employees who generally remain in the facility for more than twenty-four (24) hours;

(d) Establishments, such as motels, hotels, and boarding houses, which provide domiciliary and auxiliary commercial services, but do not provide any health related services and boarding houses which are operated by persons contracting with the United States Department of Veterans Affairs for boarding services;

(e) The remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination and recognized by that church or denomination; and

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

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

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

(4) ~~[(5)]~~ Notwithstanding any other provision of law to the contrary, no dual-license acute care beds or acute care nursing home beds that have been converted to nursing facility beds pursuant to the provisions of subsection ***(2)*** ~~[(3)]~~ of this section may be certified as Medicaid eligible after December 31, 1995, without the written authorization of the secretary.

(5) ~~[(6)]~~ Notwithstanding any other provision of law to the contrary, total dual-license acute care beds shall be limited to those licensed as of December 31, 1995, and

those with a licensure application filed and in process prior to February 10, 1996. No acute care hospital may obtain a new dual license for acute care beds unless the hospital had a licensure application filed and in process prior to February 10, 1996.

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

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

➔Section 18. KRS 216B.042 is amended to read as follows:

(1) The cabinet shall:

(a) Establish by promulgation of administrative regulation under KRS Chapter 13A reasonable application fees for licenses and promulgate other administrative regulations necessary for the proper administration of the licensure function;

(b) Issue, deny, revoke, modify, or suspend licenses or provisional licenses in accordance with the provisions of this chapter;

(c) Establish licensure standards and procedures to ensure safe, adequate, and efficient abortion facilities, health facilities and health services. These regulations, under KRS Chapter 13A, shall include~~[,]~~ but need not be limited to:

1. Patient care standards and safety standards, minimum operating

standards, minimum standards for training, required licenses for medical staff personnel, and minimum standards for maintaining patient records;

2. Licensure application and renewal procedures; and

3. Classification of health facilities and health services according to type, size, range of services, and level of care; and

(d) Compile in a single document, maintain, and make available to abortion facilities and the public during regular business hours, all licensure standards and procedures promulgated under KRS Chapter 13A related to abortion facilities.

(2) The cabinet may authorize its agents or representatives to enter upon the premises of any health care facility for the purpose of inspection, and under the conditions set forth in administrative regulations promulgated under KRS Chapter 13A by the cabinet.

(3) The cabinet may revoke licenses ~~[or certificates of need]~~for specific health facilities or health services or recommend the initiation of disciplinary proceedings for health care providers on the basis of the knowing violation of any provisions of this chapter.

➔Section 19. KRS 216B.0445 is amended to read as follows:

(1) Notwithstanding any other provision of law to the contrary, if the Federal Health Care Financing Administration issues a final regulation establishing an outpatient Medicare prospective payment system for hospitals that requires that an outpatient health facility operated by the hospital be under the same license as the hospital to achieve provider-based status, the cabinet shall, at the hospital's request, issue a new license to a hospital that owns and operates an existing or newly established outpatient health facility that lists each location operated by the hospital.

(2) Any outpatient health facility listed on the hospital's license under subsection (1) of this section shall ~~[:~~

~~(a)]~~comply with the applicable licensure regulations that pertain to the type of health services provided~~[; and~~

~~(b) Prior to the establishment of a health facility, the operation of a health facility, or the provision of health services or the addition of a health service at a location other than the hospital's main campus, obtain a certificate of need if a certificate of need would otherwise be required in the absence of subsection (1) of this section. Licensure of the outpatient health facility or service under the same license as the hospital pursuant to subsection (1) of this section shall not eliminate the requirement for a certificate of need]~~.

➔Section 20. KRS 216B.065 is amended to read as follows:

(1) Before any person enters into a contractual agreement to acquire a licensed health facility, the person shall notify the cabinet of the intent to acquire the facility or major medical equipment and of the services to be offered in the facility and its bed capacity or the use of the medical equipment. The notice shall be in writing and shall be filed at least thirty (30) days prior to entry into a contract to acquire the health facility or major medical equipment with respect to which the notice is given.

~~[(2) A certificate of need shall be required for the acquisition of a health facility or major medical equipment, only if:~~

~~(a) The notice required in this section is not filed and the arrangement will require the obligation of a capital expenditure which exceeds the capital expenditure minimum; or~~

~~(b) The cabinet finds within thirty (30) days after the date it received notice that the health services or bed capacity of the health facility will be substantially changed in being acquired.]~~

(2) ~~[(3)]~~ Donations, transfers, and leases of major medical equipment and health facilities shall be considered acquisitions of equipment and facilities, and an acquisition of medical equipment or a facility for less than fair market value shall be

considered an acquisition if the fair market value exceeds the expenditure minimum.

(3)~~[(4)]~~ Before any health facility reduces or terminates a health service or reduces its bed capacity, the facility shall notify the cabinet of its intent. The notice shall be in writing and shall be filed at least thirty (30) days prior to the reduction or termination.~~[A certificate of need shall be required for the reduction or termination only if the notice required in this section is not filed]~~.

➔Section 21. KRS 216B.066 is amended to read as follows:

(1) Before a health facility acquires major medical equipment to be used solely for research, offers a health service solely for research, or makes or obligates a capital expenditure solely for research, which exceeds the prescribed minimum, the health facility shall notify the cabinet of its intent to do so. The notice shall be in writing and shall be made sixty (60) days prior to the acquisition, offering, or making or obligation of the expenditure with respect to which notice is given. The notice shall state the use to be made of the major medical equipment, health service, or capital expenditure.

~~[(2) A certificate of need shall be required for the acquisition of major medical equipment solely for research, the offering of a health service solely for research, or the making or obligating of a capital expenditure solely for research by a health facility, only if:~~

~~(a) The notice required by this section is not filed; or~~

~~(b) The cabinet finds within sixty (60) days after it receives notice that the project or transaction for which notice is given will affect the charges of the facility for the provision of medical or other patient care services other than services which are included in the research, will substantially change the bed capacity of the facility, or will substantially change the medical or other patient care services of the facility which were offered before the acquisition, offering,~~

~~making or obligation.~~

~~(3) If major medical equipment is acquired, a health service is offered, or a capital expenditure is made or obligated and, pursuant to this section, no certificate of need is required, the equipment, service, or facilities acquired through the capital expenditure shall not be used in a manner which would affect the charges of the facility for the provision of medical or other patient care services other than that included in the research, substantially change the bed capacity of the facility, or substantially change the medical or other patient care services of the facility unless a certificate of need is issued.]~~

(2) ~~[(4)]~~ For purposes of this section, "solely for research" means patient care provided on an occasional and irregular basis and not as part of a research project.

➔Section 22. KRS 216B.115 is amended to read as follows:

(1) An appeal to the Franklin Circuit Court may be taken from any final decision of the cabinet with respect to a ~~[certificate of need application, a certificate of need, or a]~~license, by any party to the proceedings.

(2) An appeal may be taken by filing a petition for review in the Franklin Circuit Court within thirty (30) days after notice of the final decision unless a request for reconsideration has been filed, in which case the petition shall be filed within fifteen (15) days of the cabinet's decision not to reconsider or notice of its decision on reconsideration. The petition shall state completely the grounds upon which the review is sought and shall assign all errors relied upon. The petitioner shall serve a copy of the petition to each person who was a party to the proceedings. Summons shall be issued upon the petition directing the adverse party or parties to file an answer within twenty (20) days after service of summons. The cabinet shall, upon being served with the summons and within thirty (30) days thereafter, file a copy of the record, duly certified by the secretary, the cost of the record to be taxed as costs upon appeal. In lieu of filing of the record, an abstract thereof may be filed if all

parties to the appeal agree.

➔Section 23. KRS 216B.120 is amended to read as follows:

(1) Each party to the proceedings may participate as a party in the proceedings in the Circuit Court on an appeal.

(2) In case of an appeal, no new or additional evidence may be introduced in the Circuit Court except as to fraud or misconduct of some person engaged in the administration of this chapter and affecting the decision or order; the court shall hear the case upon the certified record or abstract thereof, and shall dispose of the case in a summary manner, its review being limited to determining whether the cabinet acted within its jurisdiction, whether the decision or order was procured by fraud, and whether the findings of fact in issue are supported by substantial evidence and are not clearly erroneous based upon a review of the record as a whole.

(3) The court shall enter judgment affirming, modifying, reversing, or setting aside the decision or, in its discretion, remanding the case to the cabinet for proceedings in conformity with the directions of the court. If the court affirms the issuance of the ***license***~~[certificate of need]~~, the holder of the ***license***~~[certificate]~~ shall be entitled to recover its costs of defense of the appeal, including its attorney's fees. The decision of the Circuit Court shall be final and nonappealable.

(4) In any case in which the granting of a license ~~[or certificate of need]~~is appealed by a competing health care provider, the court shall require the appellant to post a bond, with good and sufficient surety, in the sum the court deems proper, for the payment of the costs and damages as may be incurred or suffered by the ~~[certificate of need or]~~license applicant as a result of the filing and pendency of the appeal. Failure to post the bond as required by the court shall result in the dismissal of the appeal. If the decision of the cabinet granting the ~~[certificate of need or]~~license is sustained, the court shall order the appellant health care provider to pay the

applicant its costs incurred and damages suffered as a result of the filing and pendency of the appeal, which shall not be limited to the amount of the bond. The court shall not withhold the finality of its decision on the merits of the appeal pending the determination as to the costs and damages. As used in this section, "competing health care provider" means any health facility or health maintenance organization which competes with the applicant for patients, customers, the services of health care personnel, or policyholders.

➔Section 24. KRS 216B.131 is amended to read as follows:

(1) All moneys derived from applicants seeking ~~[certificates of need or]~~licenses or from any other sources connected with this chapter shall be promptly paid over to the State Treasurer, who shall deposit such moneys in a special fund which, in addition to appropriated funds, shall be used to carry out the purposes of this chapter and for no other purpose.

(2) Any fine imposed for the violation of this chapter shall, when collected, be paid into the Kentucky nursing incentive scholarship fund.

➔Section 25. KRS 216B.185 is amended to read as follows:

(1) The Office of the Inspector General shall accept accreditation by the Joint Commission or another nationally recognized accrediting organization with comparable standards and survey processes, that has been approved by the United States Centers on Medicare and Medicaid Services, as evidence that a hospital demonstrates compliance with all licensure requirements under this chapter. An annual on-site licensing inspection of a hospital shall not be conducted if the Office of the Inspector General receives from the hospital:

(a) A copy of the accreditation report within thirty (30) days of the initial accreditation and all subsequent reports; or

(b) Documentation from a hospital that holds full accreditation from an approved accrediting organization on or before July 15, 2002.

(2) Nothing in this section shall prevent the Office of the Inspector General from making licensing validation inspections and investigations as it deems necessary related to any complaints. The cabinet shall promulgate the necessary administrative regulations to implement the licensing validation process. Any administrative regulations shall reflect the validation procedures for accredited hospitals participating in the Medicare program.

(3) A hospital shall pay any licensing fees required by the cabinet in order to maintain a license.

(4) A new hospital shall not be exempt from the on-site inspection until meeting the requirements of subsection (1) of this section and administrative regulations promulgated under KRS ~~[216B.040,]~~216B.042~~[,]~~ and 216B.105 for acute, critical access, psychiatric, and rehabilitation facility requirements.

(5) Before beginning construction for the erection of a new building, the alteration of an existing building, or a change in facilities for a hospital, the hospital shall submit plans to the Office of Inspector General for approval.

(6) To the extent possible, the cabinet shall consider all national standards when promulgating administrative regulations for hospital licensure.

➔Section 26. KRS 216B.250 is amended to read as follows:

(1) For purposes of this section, "paying patient" means persons receiving health care services who pay directly for services rendered, patients with private health insurance or health maintenance organization coverage, persons receiving Medicaid or Medicaid benefits under Title XVIII and Title XIX of the Social Security Act and persons receiving veteran's health care benefits. "Paying patient" does not include medically indigent persons with no source of payment whatsoever.

(2) (a) When a copy of an itemized statement is requested by any paying patient, each health facility shall furnish to the patient within thirty (30) days of the patient's discharge or within fifteen (15) days of the patient's request, whichever is

later, one (1) copy free of charge of the itemized statement of services rendered and charges incurred by the patient.

(b) A summary statement of services rendered and charges incurred by the patient shall be included with the invoice sent by a health facility to the patient. Each invoice shall indicate that an itemized statement may be obtained upon request. The Cabinet for ***Health and Family Services***~~[Human Resources]~~ shall impose a civil fine of five hundred dollars ($500) for each violation by a health care facility for failure to provide an itemized statement as required under this section.

(c) The itemized statement shall be stamped "Kentucky Revised Statutes prohibit the use of this statement for insurance payment purposes where benefits have been assigned."

(3) Each health facility shall post in a publicly visible place in their admission, outpatient areas and, where applicable, emergency areas that an itemized statement is available to any paying patient upon request.

(4) The itemized statement rendered shall be the record maintained by the health facility that details the charges made for services rendered to patients and shall indicate whether an assignment of benefits has been obtained.

(5) Each health facility shall designate and make available appropriate staff to provide, upon patient request, an explanation of charges listed in the itemized statement.

(6) If a health facility knows of a discrepancy in the total charges as reported in an itemized statement and that which is reported to a third party payor, or at any time that a health facility becomes aware of such a discrepancy, the health facility shall provide the patient and third party payor with notification, an explanation and, if applicable, any reconciliation of the discrepancy in total charges.

➔Section 27. KRS 216B.300 is amended to read as follows:

As used in KRS 216B.300 to 216B.320 and KRS 216B.990***(4)***~~[(5)]~~, unless the context

requires otherwise:

(1) "Cabinet" means the Cabinet for Health and Family Services or its designee. "Designee" means any agency established under KRS Chapter 211 or KRS 147A.050 whose duties related to this chapter shall be set forth in administrative regulation;

(2) "Secretary" means the secretary of the Cabinet for Health and Family Services;

(3) "Boarder" means a person who does not require supervision or assistance related to medication, activities of daily living, or a supervised plan of care; and

(4) "Boarding home" means any home, facility, institution, lodging, or other establishment, however named, which accommodates three (3) or more adults not related by blood or marriage to the owner, operator, or manager, and which offers or holds itself out to offer room and board on a twenty-four (24) hour basis for hire or compensation. It shall not include any facility which is otherwise licensed and regulated by the cabinet or any hotel as defined in KRS 219.011(3).

➔Section 28. KRS 216B.332 is amended to read as follows:

(1) To be eligible for a certificate of compliance, a continuing care retirement community shall certify in writing to the cabinet and shall disclose in writing to each of its residents that:

(a) None of the health facilities or health services operated by the continuing care retirement community shall apply for or become certified for participation in the Medicaid program; and

(b) No claim for Medicaid reimbursement shall be submitted for any person for any health service provided by the continuing care retirement community.

(2) A continuing care retirement community may establish one (1) bed at the nursing home level of care for every four (4) living units or personal care beds operated by the continuing care retirement community collectively. All residents in nursing home beds shall be assessed using the Health Care Financing Administration or

Centers for Medicare and Medicaid Services approved long-term care resident assessment instrument.

(3) Admissions to continuing care retirement community nursing home beds shall be exclusively limited to on-campus residents. A resident shall not be admitted to a continuing care retirement community nursing home bed prior to ninety (90) days of residency in the continuing care retirement community unless the resident experiences a significant change in health status documented by a physician. No resident admitted to a nursing home bed shall be transferred or discharged without thirty (30) days prior written notice to the resident or his or her guardian.

(4) A continuing care retirement community shall assist each resident upon a move-out notice to find appropriate living arrangements. Each continuing care retirement community shall share information on alternative living arrangements provided by the Department for Aging and Independent Living at the time a move-out notice is given to a resident. The written agreement executed by the resident and the continuing care retirement community shall contain provisions for assisting any resident who has received a move-out notice to find appropriate living arrangements, prior to the actual move-out date.

~~[(5) Home health services provided by a continuing care retirement community to its on-campus residents shall not require a certificate of need.]~~

➔Section 29. KRS 216B.455 is amended to read as follows:

(1) ~~[A certificate of need shall be required for all Level I psychiatric residential treatment facilities. The application for a certificate of need shall include formal written agreements of cooperation that identify the nature and extent of the proposed working relationship between the proposed Level I psychiatric residential treatment facility and each of the following agencies, organizations, or facilities located in the service area of the proposed facility:~~

~~(a) Regional interagency council for children with emotional disability or severe~~

~~emotional disability as defined in KRS 200.509;~~

~~(b) Department for Community Based Services;~~

~~(c) Local school districts;~~

~~(d) At least one (1) psychiatric hospital; and~~

~~(e) Any other agency, organization, or facility deemed appropriate by the cabinet.~~

~~(2) Notwithstanding provisions for granting of a nonsubstantive review of a certificate of need application under KRS 216B.095, the cabinet shall review and approve the nonsubstantive review of an application seeking to increase the number of beds as permitted by KRS 216B.450 if the application is submitted by an eight (8) bed or sixteen (16) bed Level I psychiatric residential treatment facility licensed and operating or holding an approved certificate of need on July 13, 2004. The cabinet shall base its approval of expanded beds upon the Level I psychiatric residential treatment facility's ability to meet standards designed by the cabinet to provide stability of care. The standards shall be promulgated by the cabinet in an administrative regulation in accordance with KRS Chapter 13A. An application under this subsection shall not be subject to any moratorium relating to certificate of need.~~

~~(3)]~~All Level I psychiatric residential treatment facilities shall comply with the licensure requirements as set forth in KRS 216B.105.

(2) ~~[(4)]~~ All Level I psychiatric residential treatment facilities shall be certified by the Joint Commission, the Council on Accreditation of Services for Families and Children, or any other accrediting body with comparable standards that is recognized by the state.

(3) ~~[(5)]~~ A Level I psychiatric residential treatment facility shall not be located in or on the grounds of a psychiatric hospital. More than one (1) freestanding Level I psychiatric residential treatment facility may be located on the same campus that is not in or on the grounds of a psychiatric hospital.

~~[(6) The total number of Level I psychiatric residential treatment facility beds shall not exceed three hundred and fifteen (315) beds statewide.~~

~~(7) (a) The Cabinet for Health and Family Services shall investigate the need for specialty foster care and post-treatment services for persons discharged from Level I and Level II psychiatric residential treatment facilities.~~

~~(b) The cabinet shall report to the Governor and the Legislative Research Commission by August 1, 2011, detailing information on specialty foster care and post-treatment services for persons discharged from Level I and Level II psychiatric residential treatment facilities.]~~

➔Section 30. KRS 216B.457 is amended to read as follows:

(1) ~~[A certificate of need shall be required for all Level II psychiatric residential treatment facilities. The need criteria for the establishment of Level II psychiatric residential treatment facilities shall be in the state health plan.~~

~~(2) An application for a certificate of need for Level II psychiatric residential treatment facilities shall not exceed fifty (50) beds. Level II facility beds may be located in a separate part of a psychiatric hospital, a separate part of an acute care hospital, or a Level I psychiatric residential treatment facility if the Level II beds are located on a separate floor, in a separate wing, or in a separate building. A Level II facility shall not refuse to admit a patient who meets the medical necessity criteria and facility criteria for Level II facility services. Nothing in this section and KRS 216B.450 and 216B.455 shall be interpreted to prevent a psychiatric residential treatment facility from operating both a Level I psychiatric residential treatment facility and a Level II psychiatric residential treatment facility.~~

~~(3) The application for a Level II psychiatric residential treatment facility certificate of need shall include formal written agreements of cooperation that identify the nature and extent of the proposed working relationship between~~

~~the proposed Level II psychiatric residential treatment facility and each of the following agencies, organizations, or entities located in the service area of the proposed facility:~~

~~(a) Regional interagency council for children with emotional disability or severe emotional disability created under KRS 200.509;~~

~~(b) Community board for mental health or individuals with an intellectual disability established under KRS 210.380;~~

~~(c) Department for Community Based Services;~~

~~(d) Local school districts;~~

~~(e) At least one (1) psychiatric hospital; and~~

~~(f) Any other agency, organization, or entity deemed appropriate by the cabinet.~~

~~(4) The application for a certificate of need shall include:~~

~~(a) The specific number of beds proposed for each age group and the specific, specialized program to be offered;~~

~~(b) An inventory of current services in the proposed service area; and~~

~~(c) Clear admission and discharge criteria, including age, sex, and other limitations.~~

~~(5)]~~All Level II psychiatric residential treatment facilities shall comply with the licensure requirements as set forth in KRS 216B.105.

(2) ~~[(6)]~~ All Level II psychiatric residential treatment facilities shall be certified by the Joint Commission, the Council on Accreditation of Services for Families and Children, or any other accrediting body with comparable standards that are recognized by the Centers for Medicare and Medicaid Services.

(3) ~~[(7)]~~ A Level II psychiatric residential treatment facility shall be under the clinical supervision of a qualified mental health professional with training or experience in mental health treatment of children and youth.

(4) ~~[(8)]~~ Treatment services shall be provided by qualified mental health professionals

or qualified mental health personnel. Individual staff who will provide educational programs shall meet the employment standards outlined by the Kentucky Board of Education and the Education Professional Standards Board.

(5) ~~[(9)]~~ A Level II psychiatric residential treatment facility shall meet the following requirements with regard to professional staff:

(a) A licensed psychiatrist, who is board-eligible or board-certified as a child or adult psychiatrist, shall be employed or contracted to meet the treatment needs of the residents and the functions that shall be performed by a psychiatrist;

(b) If a Level II psychiatric residential treatment facility has residents ages twelve (12) and under, the licensed psychiatrist shall be a board-eligible or board-certified child psychiatrist; and

(c) The licensed psychiatrist shall be present in the facility to provide professional services to the facility's residents at least weekly.

(6) ~~[(10)]~~ A Level II psychiatric residential treatment facility shall:

(a) Prepare a written staffing plan that is tailored to meet the needs of the specific population of children and youth that will be admitted to the facility based on the facility's admission criteria. The written staffing plan shall include but not be limited to the following:

1. Specification of the direct care per-patient staffing ratio that the facility shall adhere to during waking hours and during sleeping hours;
2. Delineation of the number of direct care staff per patient, including the types of staff and the mix and qualifications of qualified mental health professionals and qualified mental health personnel, that shall provide direct care and will comprise the facility's per-patient staffing ratio;
3. Specification of appropriate qualifications for individuals included in the per-patient staffing ratio by job description, education, training, and experience;

4. Provision for ensuring compliance with its written staffing plan, and specification of the circumstances under which the facility may deviate from the per-patient staffing ratio due to patient emergencies, changes in patient acuity, or changes in patient census; and

5. Provision for submission of the written staffing plan to the cabinet for approval as part of the facility's application for initial licensure.

No initial license to operate as a Level II psychiatric residential treatment facility shall be granted until the cabinet has approved the facility's written staffing plan. Once a facility is licensed, it shall comply with its approved written staffing plan and, if the facility desires to change its approved per-patient staffing ratio, it shall submit a revised plan and have the plan approved by the cabinet prior to implementation of the change;

(b) Require full-time professional and direct care staff to meet the continuing education requirements of their profession or be provided with forty (40) hours per year of in-service training; and

(c) Develop and implement a training plan for all staff that includes but is not limited to the following:

1. Behavior-management procedures and techniques;

2. Physical-management procedures and techniques;

3. First aid;

4. Cardiopulmonary resuscitation;

5. Infection-control procedures;

6. Child and adolescent growth and development;

7. Training specific to the specialized nature of the facility;

8. Emergency and safety procedures; and

9. Detection and reporting of child abuse and neglect.

(7) ~~[(11)]~~ A Level II psychiatric residential treatment facility shall require a criminal

records check to be completed on all employees and volunteers. The employment or volunteer services of an individual shall be governed by KRS 17.165, with regard to a criminal records check. A new criminal records check shall be completed at least every two (2) years on each employee or volunteer.

(8) ~~[(12)]~~ (a) Any employee or volunteer who has committed or is charged with the commission of a violent offense as specified in KRS 439.3401, a sex crime specified in KRS 17.500, or a criminal offense against a victim who is a minor as specified in KRS 17.500 shall be immediately removed from contact with a child within the residential treatment center until the employee or volunteer is cleared of the charge.

(b) An employee or volunteer under indictment, legally charged with felonious conduct, or subject to a cabinet investigation shall be immediately removed from contact with a child.

(c) The employee or volunteer shall not be allowed to work with the child until a prevention plan has been written and approved by the cabinet, the person is cleared of the charge, or a cabinet investigation reveals an unsubstantiated finding, if the charge resulted from an allegation of child abuse, neglect, or exploitation.

(d) Each employee or volunteer shall submit to a check of the central registry. An individual listed on the central registry shall not be a volunteer at or be employed by a Level II psychiatric residential treatment facility.

(e) Any employee or volunteer removed from contact with a child pursuant to this subsection may, at the discretion of the employer, be terminated, reassigned to a position involving no contact with a child, or placed on administrative leave with pay during the pendency of the investigation or proceeding.

(9) ~~[(13)]~~ An initial treatment plan of care shall be developed and implemented for each resident, and the plan of care shall be based on initial history and ongoing

assessment of the resident's needs and strengths, with an emphasis on active treatment, transition planning, and after-care services, and shall be completed within seventy-two (72) hours of admission.

(10) ~~[(14)]~~ A comprehensive treatment plan of care shall be developed and implemented for each resident, and the plan of care shall be based on initial history and ongoing assessment of the resident's needs and strengths, with an emphasis on active treatment, transition planning, and after-care services, and shall be completed within ten (10) calendar days of admission.

(11) ~~[(15)]~~ A review of the treatment plan of care shall occur at least every thirty (30) days following the first ten (10) days of treatment and shall include the following documentation:

(a) Dated signatures of appropriate staff, parent, guardian, legal custodian, or conservator;

(b) An assessment of progress toward each treatment goal and objective with revisions as indicated; and

(c) A statement of justification for the level of services needed, including suitability for treatment in a less-restrictive environment and continued services.

(12) ~~[(16)]~~ A Level II psychiatric residential treatment facility shall provide or arrange for the provision of qualified dental, medical, nursing, and pharmaceutical care for residents. The resident's parent, guardian, legal custodian, or conservator may choose a professional for nonemergency services.

(13) ~~[(17)]~~ A Level II psychiatric residential treatment facility shall ensure that opportunities are provided for recreational activities that are appropriate and adapted to the needs, interests, and ages of the residents.

(14) ~~[(18)]~~ A Level II psychiatric residential treatment facility shall assist residents in the independent exercise of health, hygiene, and grooming practices.

(15) ~~[(19)]~~ A Level II psychiatric residential treatment facility shall assist each resident in securing an adequate allowance of personally owned, individualized, clean, and seasonal clothes that are the correct size.

(16) ~~[(20)]~~ A Level II psychiatric residential treatment facility shall assist, educate, and encourage each resident in the use of dental, physical, or prosthetic appliances or devices and visual or hearing aids.

(17) ~~[(21)]~~ The cabinet shall promulgate administrative regulations that include but are not limited to the following:

(a) Establishing requirements for tuberculosis skin testing for staff of a Level II psychiatric residential treatment facility;

(b) Ensuring that accurate, timely, and complete resident assessments are conducted for each resident of a Level II psychiatric residential treatment facility;

(c) Ensuring that accurate, timely, and complete documentation of the implementation of a resident's treatment plan of care occurs for each resident of a Level II psychiatric residential treatment facility;

(d) Ensuring that an accurate, timely, and complete individual record is maintained for each resident of a Level II psychiatric residential treatment facility;

(e) Ensuring that an accurate, timely, and complete physical examination is conducted for each resident of a Level II psychiatric residential treatment facility;

(f) Ensuring accurate, timely, and complete access to emergency services is available for each resident of a Level II psychiatric residential treatment facility; and

(g) Ensuring that there is accurate, timely, and complete administration of medications for each resident of a Level II psychiatric residential treatment

facility.

(18) ~~[(22)]~~ The cabinet shall, within ninety (90) days of July 15, 2010, promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section and KRS 216B.450 and 216B.455. When promulgating the administrative regulations, the cabinet shall not consider only staffing ratios when evaluating the written staffing plan of an applicant, but shall consider the applicant's overall ability to provide for the needs of patients.

(19) ~~[(23)]~~ The cabinet shall report, no later than August 1 of each year, to the Interim Joint Committee on Health and Welfare regarding the implementation of this section and KRS 216B.450 and 216B.455. The report shall include but not be limited to information relating to resident outcomes, such as lengths of stay in the facility, locations residents were discharged to, and whether residents were readmitted to a Level II psychiatric residential treatment facility within a twelve (12) month period.

➔Section 31. KRS 216B.990 is amended to read as follows:

(1) Any person who, in willful violation of this chapter, operates a health facility or abortion facility without first obtaining a license or continues to operate a health facility or abortion facility after a final decision suspending or revoking a license shall be fined not less than five hundred dollars ($500) nor more than ten thousand dollars ($10,000) for each violation.

(2) ~~[Any person who, in willful violation of this chapter, acquires major medical equipment, establishes a health facility, or obligates a capital expenditure without first obtaining a certificate of need, or after the applicable certificate of need has been withdrawn, shall be fined one percent (1%) of the capital expenditure involved but not less than five hundred dollars ($500) for each violation.~~

~~(3)]~~Any hospital acting by or through its agents or employees which violates any provision of KRS 216B.400 shall be punished by a fine of not less than one hundred

dollars ($100) nor more than five hundred dollars ($500).

(3) ~~[(4)]~~ Any health facility which willfully violates KRS 216B.250 shall be fined one hundred dollars ($100) per day for failure to post required notices and one hundred dollars ($100) per instance for willfully failing to provide an itemized statement within the required time frames.

(4) ~~[(5)]~~ In addition to the civil penalties established under KRS 216B.306(1) and (4), any person who advertises, solicits boarders, or operates a boarding home without first obtaining a registration as required by KRS 216B.305 and any person who aids or abets the operation of a boarding home that is not registered shall be imprisoned for no more than twelve (12) months.

(5) ~~[(6)]~~ Any person or entity establishing, managing, or operating an abortion facility or conducting the business of an abortion facility which otherwise violates any provision of this chapter or any administrative regulation promulgated thereunder regarding abortion facilities shall be subject to revocation or suspension of the license of the abortion facility. In addition, any violation of any provision of this chapter regarding abortion facilities or any administrative regulation related thereto by intent, fraud, deceit, unlawful design, willful and deliberate misrepresentation, or by careless, negligent, or incautious disregard for the statute or administrative regulation, either by persons acting individually or in concert with others, shall constitute a violation and shall be punishable by a fine not to exceed one thousand dollars ($1,000) for each offense. Each day of continuing violation shall be considered a separate offense. The venue for prosecution of the violation shall be in any county of the state in which the violation, or any portion thereof, occurred.

(6) ~~[(7)]~~ Any hospital acting by or through its agents or employees that violates any provision of KRS 216B.150 shall be punished by a fine of not less than one hundred dollars ($100) nor more than five hundred dollars ($500) for each violation.

➔Section 32. KRS 218A.175 is amended to read as follows:

(1) (a) As used in this section, "pain management facility" means a facility where the majority of patients of the practitioners at the facility are provided treatment for pain that includes the use of controlled substances and:

1. The facility's primary practice component is the treatment of pain; or
2. The facility advertises in any medium for any type of pain management services.

(b) "Pain management facility" does not include the following:

1. A hospital, including a critical access hospital, as defined in KRS Chapter 216, a facility owned by the hospital, or the office of a hospital-employed physician;
2. A school, college, university, or other educational institution or program to the extent that it provides instruction to individuals preparing to practice as physicians, podiatrists, dentists, nurses, physician assistants, optometrists, or veterinarians;
3. A hospice program or residential hospice facility licensed under KRS Chapter 216B;
4. An ambulatory surgical center licensed under KRS Chapter 216B; or
5. A long-term-care facility as defined in KRS 216.510.

(2) (a) Only a physician having a full and active license to practice medicine issued under KRS Chapter 311 shall have an ownership or investment interest in a pain management facility. Credit extended by a financial institution as defined in KRS 136.500 to the facility shall not be deemed an investment interest under this subsection. This ownership or investment requirement shall not be enforced against any pain management facility existing and operating on April 24, 2012, unless there is an administrative sanction or criminal conviction relating to controlled substances imposed on the facility, any person employed by the facility, or any person working at the facility as an independent

contractor for an act or omission done within the scope of the facility's licensure or the person's employment.

(b) A facility qualifying for the exemption permitted by paragraph (a) of this subsection whose ownership has been continuously held jointly and exclusively by practitioners having full and active licenses to practice in Kentucky since April 24, 2012, may, after June 24, 2015:

1. Open and operate no more than two (2) additional facilities in locations other than those locations existing and operating on April 24, 2012;
2. Transfer whole or partial ownership between existing practitioner owners;
3. Transfer whole or partial ownership interests to new owners if the new owners are physicians having full and active licenses to practice in Kentucky and the facility notifies the cabinet of the transfer thirty (30) days before it occurs; and
4. Pass the ownership interest of a deceased former owner through that person's estate to a physician having a full and active license to practice in Kentucky without disqualifying the facility's grandfathered status under this subsection if the facility notifies the cabinet of the transfer thirty (30) days before it occurs in cases where the interest is being transferred to a physician who is not an existing owner in the facility.

(3) Regardless of the form of facility ownership, beginning on July 20, 2012, at least one (1) of the owners or an owner's designee who is a physician employed by and under the supervision of the owner shall be physically present practicing medicine in the facility for at least fifty percent (50%) of the time that patients are present in the facility, and that physician owner or designee shall:

(a) Hold a current subspecialty certification in pain management by a member board of the American Board of Medical Specialties, or hold a current

certificate of added qualification in pain management by the American Osteopathic Association Bureau of Osteopathic Specialists;

(b) Hold a current subspecialty certification in hospice and palliative medicine by a member board of the American Board of Medical Specialties, or hold a current certificate of added qualification in hospice and palliative medicine by the American Osteopathic Association Bureau of Osteopathic Specialists;

(c) Hold a current board certification by the American Board of Pain Medicine;

(d) Hold a current board certification by the American Board of Interventional Pain Physicians;

(e) Have completed a fellowship in pain management or an accredited residency program that included a rotation of at least five (5) months in pain management; or

(f) If the facility is operating under a registration filed with the Kentucky Board of Medical Licensure, have completed or hold, or be making reasonable progress toward completing or holding, a certification or training substantially equivalent to the certifications or training specified in this subsection, as authorized by the Kentucky Board of Medical Licensure by administrative regulation.

(4) A pain management facility shall accept private health insurance as one (1) of the facility's allowable forms of payment for goods or services provided and shall accept payment for services rendered or goods provided to a patient only from the patient or the patient's insurer, guarantor, spouse, parent, guardian, or legal custodian.

(5) If the pain management facility is operating under a license issued by the cabinet, the cabinet shall include and enforce the provisions of this section as additional conditions of that licensure. If the pain management facility is operating as the private office or clinic of a physician under KRS 216B.020~~[(2)]~~, the Kentucky

Board of Medical Licensure shall enforce the provisions of this section. The provisions of this subsection shall not apply to the investigation or enforcement of criminal liability.

(6) Any person who violates the provisions of this section shall be guilty of a Class A misdemeanor.

➔Section 33. KRS 304.17-312 is amended to read as follows:

As used in KRS 304.17-313, 304.18-037, 304.32-280, and 304.38-210:

(1) "Home health agency" means a public agency or private organization, or a subdivision of such an agency or organization which is licensed as a home health agency by the ***Cabinet for Health and Family Services***~~[Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~ and is certified to participate as a home health agency under Title XVIII of the Social Security Act.

(2) "Home health care" means the care and treatment provided by a home health agency which is prescribed and supervised by a physician. The care and treatment shall include but not be limited to one (1) or more of the following:

(a) Part-time or intermittent skilled nursing services provided by an advanced practice registered nurse, registered nurse, or licensed practical nurse;

(b) Physical, respiratory, occupational, or speech therapy;

(c) Home health aide services;

(d) Medical appliances and equipment, drugs and medication, and laboratory services, to the extent that such items and services would have been covered under the policy if the covered person had been in a hospital.

(3) "Home health aide services" means those services provided by a home health aide and supervised by a registered nurse which are directed towards the personal care of the patient. Such services shall include but not be limited to the following:

(a) Helping the patient with bath, care of mouth, skin, and hair;

(b) Helping the patient to the bathroom or in using a bedpan;

(c) Helping the patient in and out of bed and assisting with ambulation;

(d) Helping the patient with prescribed exercises which the patient and home health aide have been taught by appropriate professional personnel;

(e) Assisting with medication ordinarily self-administered that has been specifically ordered by a physician;

(f) Performing incidental household services as are essential to the patient's health care at home provided that such services would have been performed if the patient was in a hospital or skilled nursing facility; and

(g) Reporting to the professional nurse supervisor changes in the patient's condition or family situation.

➔Section 34. KRS 304.17-313 is amended to read as follows:

(1) All insurers issuing individual health insurance policies in the Commonwealth providing coverage on an expense incurred basis shall make available and offer to the purchaser coverage for home health care. The coverage may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than sixty (60) in any calendar year or in any continuous period of twelve (12) months for each person covered under the policy. Each visit by an authorized representative of a home health agency shall be considered as one (1) home health care visit, except that at least four (4) hours of home health aide service shall be considered as one (1) home health visit.

(2) Home health care coverage shall be subject to the same deductible and coinsurance provisions as are other services covered by insurers issuing individual health insurance policies in the Commonwealth.

(3) Home health care shall not be reimbursed unless an attending physician certifies that hospitalization or confinement in a skilled nursing facility ***licensed by the Cabinet for Health and Family Services*** ~~[as defined by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~ would

otherwise be required if home health care was not provided.

(4) Medicare beneficiaries shall be deemed eligible to receive home health care benefits under an individual health insurance policy providing coverage on an expense incurred basis provided that the policy shall only pay for those home health care services which are not paid for by Medicare and do not exceed the maximum liability of the policy.

(5) Pursuant to the provisions of this section, all insurers issuing individual health insurance policies in the Commonwealth on an expense incurred basis shall inform the beneficiaries of such policies, in writing, of the specific home health care benefits which are covered. Such written notification shall take place at the time of issuance or reissuance of the policy.

➔Section 35. KRS 304.17-317 is amended to read as follows:

(1) All individual health insurance policies providing coverage on an expense incurred basis shall provide coverage for health care treatment or services rendered by ambulatory surgical centers ***licensed by the Cabinet for Health and Family Services***~~[approved by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~. The health coverage for health care treatment or services rendered by an ambulatory surgical center shall be on the same basis as coverage provided for the same health care treatment or services rendered by a hospital.

(2) The requirements of this section shall apply to all health insurance policies delivered or issued for delivery in this state on and after October 1, 1978.

➔Section 36. KRS 304.17A-147 is amended to read as follows:

Notwithstanding any provision of law, a health plan issued or renewed on or after July 15, 2000, that provides coverage for surgical first assisting or intraoperative surgical care benefits or services shall be construed as providing coverage for a certified surgical assistant who performs services as identified in KRS 216B.015***13***~~[(16)]~~.

➔Section 37. KRS 304.17A-1473 is amended to read as follows:

Notwithstanding any provision of law, a health benefit plan issued or renewed on or after July 15, 2001, that provides coverage for surgical first assisting or intraoperative surgical care benefits or services shall be construed as providing coverage for a certified surgical assistant or physician assistant who performs services as identified in KRS 216B.015***(13)***~~[(16)]~~.

➔Section 38. KRS 304.18-035 is amended to read as follows:

(1) All group or blanket health insurance policies and certificates issued thereunder providing coverage on an expense incurred basis shall provide coverage for health care treatment or services rendered by ambulatory surgical centers ***licensed by the Cabinet for Health and Family Services***~~[approved by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~. The coverage for health care treatment or services rendered by an ambulatory surgical center shall be on the same basis as coverage provided for the same health care treatment or services rendered by a hospital.

(2) The requirements of this section shall apply to all insurance policies, and certificates issued thereunder, delivered or issued for delivery in this state on and after October 1, 1978.

➔Section 39. KRS 304.18-037 is amended to read as follows:

(1) All insurers issuing group or blanket health insurance policies and certificates issued thereunder in the Commonwealth providing coverage on an expense incurred basis shall make available and offer to the master policyholder coverage for home health care. The coverage may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than sixty (60) in any calendar year or in any continuous period of twelve (12) months for each person covered under the policy. Each visit by an authorized representative of a home health agency shall be considered as one (1) home health

care visit except that at least four (4) hours of home health aide service shall be considered as one (1) home health visit.

(2) Home health care coverage shall be subject to the same deductible and coinsurance provisions as are other services covered by insurers issuing group or blanket health insurance policies in the Commonwealth.

(3) Home health care shall not be reimbursed unless an attending physician certifies that hospitalization or confinement in a skilled nursing facility ***licensed by the Cabinet for Health and Family Services***~~[as defined by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~ would otherwise be required if home health care was not provided.

(4) Medicare beneficiaries shall be deemed eligible to receive home health care benefits under a group or blanket health insurance policy provided that the policy shall only pay for those home health care services which are not paid for by Medicare and do not exceed the maximum liability of the policy.

(5) Pursuant to the provisions of this section, all insurers issuing group or blanket health insurance policies and certificates issued thereunder in the Commonwealth providing coverage on an expense incurred basis which include coverage for home health care shall inform the beneficiaries of such policies, in writing, of the specific home health care benefits which are covered. Such written notification shall take place at the time of issuance or reissuance of the policy.

➔Section 40. KRS 304.32-156 is amended to read as follows:

(1) All individual or group service or indemnity type contracts and all certificates thereunder issued by a nonprofit corporation shall provide coverage for health care treatment or services rendered by ambulatory surgical centers ***licensed by the Cabinet for Health and Family Services***~~[approved by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~. The coverage for health care treatment or services rendered by an ambulatory surgical

center shall be on the same basis as coverage provided for the same health care treatment or services rendered by a hospital.

(2) The requirements of this section shall apply to all member or subscriber contracts and all certificates thereunder, delivered or issued for delivery in this state on or after October 1, 1978.

➔Section 41. KRS 304.32-280 is amended to read as follows:

(1) All nonprofit hospital, medical-surgical, dental and health service corporations issuing policies in the Commonwealth which provide hospital, medical, or surgical expense benefits shall make available and offer to include benefits for home health care. On group benefits the option for home health care benefits shall be made available and offered to the master policyholder. The coverage may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than sixty (60) in any calendar year or in any continuous period of twelve (12) months for each person covered under the policy. Each visit by an authorized representative of a home health agency shall be considered as one (1) home health care visit except that at least four (4) hours of home health aide service shall be considered as one (1) home health visit.

(2) Home health care coverage shall be subject to the same deductible and coinsurance provisions as are other services covered by nonprofit hospital, medical-surgical, dental and health service corporations which issue policies in the Commonwealth that provide hospital, medical, or surgical expense benefits.

(3) Home health care shall not be reimbursed unless an attending physician certifies that hospitalization or confinement in a skilled nursing facility ***licensed by the Cabinet for Health and Family Services*** ~~[as defined by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~ would otherwise be required if home health care was not provided.

(4) Medicare beneficiaries shall be deemed eligible to receive home health care benefits

under a policy, contract, plan entered into, issued, delivered or amended in this state by a nonprofit hospital, medical-surgical, dental and health service corporation which provides hospital, medical or surgical expense benefits provided that the policy, contract or plan shall only pay for those home health care services which are not paid for by Medicare and do not exceed the maximum liability of the policy, contract or plan.

(5) Pursuant to the provisions of this section, all nonprofit hospital, medical-surgical, dental and health service corporations issuing policies in the Commonwealth which provide hospital, medical, or surgical expense benefits or coverage for home health care shall inform the beneficiaries of such policies, in writing, of the specific home health care benefits which are covered. Such written notification shall take place at the time of issuance or reissuance of the policy.

➔Section 42. KRS 304.38-020 is amended to read as follows:

(1) The purpose of this subtitle is to encourage and guarantee the development of health maintenance organizations by licensing and regulating their operation to insure that they provide high quality health care services through state licensed organizations meeting reasonable standards as to administration, services, and financial soundness.

(2) It is the intent of this subtitle to complement the provisions of the ~~[certificate of need and]~~licensure provisions of KRS Chapter 216B.

(3) It is the intent of this subtitle to complement the Federal Health Maintenance Organization Act of 1973, as amended (P.L. 93-222), and nothing in this subtitle is intended to be in conflict with the federal statutes and regulations promulgated thereunder.

➔Section 43. KRS 304.38-040 is amended to read as follows:

(1) A corporation, limited liability company, or partnership may apply to the commissioner for and obtain a certificate of authority to establish and operate a

health maintenance organization in compliance with this subtitle.

(2) Health maintenance organizations which are corporations may be organized by applying the provisions of KRS Chapter 271B, if for profit, and KRS Chapter 273, if for nonstock, nonprofit, to the extent that the same are not inconsistent with the express provisions of this subtitle.

(3) Each application for a certificate of authority shall be submitted to the commissioner upon a form prescribed by the commissioner and shall set forth or be accompanied by:

(a) ~~[Evidence that the applicant has been issued a certificate of need in accordance with the provisions of KRS Chapter 216B or evidence that no certificate of need is required by KRS Chapter 216B;~~

~~(b)]~~Articles of incorporation, articles of organization, partnership agreement, or other applicable documents in quadruplicate, acknowledged and verified by the applicant;

(b)~~[(c)]~~ The initial bylaws, operating agreement, or other equivalent documents of the organization in triplicate, or any other similar documents;

(c)~~[(d)]~~ A statement which shall include describing the health maintenance organization:

1. The health services to be offered;
2. The financial risks to be assumed;
3. The initial geographic area to be served;
4. Pro forma financial projections for the first three (3) years of operations including the assumptions the projections are based upon;
5. The sources of working capital and funding;
6. A description of the persons to be covered by the health maintenance organization;
7. Any proposed reinsurance arrangements;

8. Any proposed management, administrative, or cost-sharing arrangements; and

9. A description of the health maintenance organization's proposed method of marketing;

(d) ~~[(e)]~~ The names, addresses, and positions of the initial board of directors, board of trustees, or other governing body responsible for the conduct of the affairs of the applicant;

(e) ~~[(f)]~~ Any proposed evidence of coverage to be issued by the applicant to individuals, enrollees, groups, or other contract holders; and

(f) ~~[(g)]~~ Evidence of financial responsibility as provided in KRS 304.38-060.

➔Section 44. KRS 304.38-090 is amended to read as follows:

Organizations subject to the provisions of this subtitle shall make and file with the commissioner and the ***Cabinet for Health and Family Services*** ~~[Kentucky Certificate of Need and Licensure Board]~~ annually before March 1 of each year, a statement under oath upon a form to be prescribed by the commissioner covering the preceding year, and shall include (a) a financial statement of the organization, including a balance sheet, receipts, and disbursements for the preceding year; (b) the number of persons enrolled during the year, the number of enrollees as of the end of the year, the number of enrollments terminated during the year, and any other information relating to the operation of the health maintenance organization as may be prescribed by the commissioner in order to enable the commissioner to evaluate the performance of the health maintenance organization.

➔Section 45. KRS 304.38-130 is amended to read as follows:

(1) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this subtitle if the commissioner finds that any of the conditions exist for which the commissioner could suspend or revoke a certificate of authority as provided in Subtitles 2 and 3 of this chapter or if the

commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted under KRS 304.38-040, unless amendments to such submissions have been filed with and approved by the commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of KRS 304.38-050 or Subtitle 17A of this chapter;

(c) The health maintenance organization does not provide or arrange for health care services as approved by the commissioner in KRS 304.38-050(1)(a);

(d) The ***Cabinet for Health and Family Services*** ~~[certificate of need and licensure board]~~ certifies to the commissioner that the health maintenance organization fails to meet the requirements of the board or that the health maintenance organization is unable to fulfill its obligations to furnish health care services;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(g) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(h) The health maintenance organization has otherwise failed to substantially comply with this subtitle.

(2) If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of the suspension,

enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(3) If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit the further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage. If the commissioner permits such further operation the health maintenance organization will continue to collect the periodic prepayments required of enrollees.

➔Section 46. KRS 304.38-210 is amended to read as follows:

(1) Health maintenance organizations issuing policies in the Commonwealth which provide hospital, medical, or surgical expense benefits shall make available and offer to include benefits for home health care. On group benefits the option for home health care benefits shall be made available and offered to the master policyholder. The coverage may contain a limitation on the number of home health care visits for which benefits are payable, but the number of such visits shall not be less than sixty (60) in any calendar year or in any continuous period of twelve (12) months for each person covered under the policy. Each visit by an authorized representative of a home health agency shall be considered as one (1) home health care visit except that at least four (4) hours of home health service shall be considered as one (1) home health visit.

(2) Home health care coverage shall be subject to the same deductible and coinsurance

provisions as are other services covered by health maintenance organizations which issue policies in the Commonwealth that provide hospital, medical, or surgical expense benefits.

(3) Home health care shall not be reimbursed unless an attending physician certifies that hospitalization or confinement in a skilled nursing facility ***licensed by the Cabinet for Health and Family Services***~~[as defined by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~ would otherwise be required if home health care was not provided.

(4) Medicare beneficiaries shall be deemed eligible to receive home health care benefits under a policy, contract or plan entered into, issued, delivered, or amended in this state by a health maintenance organization which provides hospital, medical, or surgical expense benefits provided that the policy, contract or plan shall only pay for those home health care services which are not paid for by Medicare and do not exceed the maximum liability of the policy, contract or plan.

(5) Pursuant to the provisions of this section, all health maintenance organizations issuing policies in the Commonwealth which provide hospital, medical, or surgical expense benefits or coverage for home health care shall inform the beneficiaries of such policies, in writing, of the specific home health care benefits which are covered. Such written notification shall take place at the time of issuance or reissuance of the policy.

➔Section 47. KRS 311.377 is amended to read as follows:

(1) Any person who applies for, or is granted staff privileges after June 17, 1978, by any health services organization subject to licensing under ~~[the certificate of need and licensure provisions of]~~KRS Chapter 216B, shall be deemed to have waived as a condition of such application or grant, any claim for damages for any good faith action taken by any person who is a member, participant in or employee of or who furnishes information, professional counsel, or services to any committee, board,

commission, or other entity which is duly constituted by any licensed hospital, licensed hospice, licensed home health agency, health insurer, health maintenance organization, health services corporation, organized medical staff, medical society, or association affiliated with the American Medical Association, American Podiatry Association, American Dental Association, American Osteopathic Association, or the American Hospital Association, or a medical care foundation affiliated with such a medical society or association, or governmental or quasigovernmental agency when such entity is performing the designated function of review of credentials or retrospective review and evaluation of the competency of professional acts or conduct of other health care personnel. This subsection shall have equal application to, and the waiver be effective for, those persons who, subsequent to June 17, 1978, continue to exercise staff privileges previously granted by any such health services organization.

(2) At all times in performing a designated professional review function, the proceedings, records, opinions, conclusions, and recommendations of any committee, board, commission, medical staff, professional standards review organization, or other entity, as referred to in subsection (1) of this section shall be confidential and privileged and shall not be subject to discovery, subpoena, or introduction into evidence, in any civil action in any court or in any administrative proceeding before any board, body, or committee, whether federal, state, county, or city, except as specifically provided with regard to the board in KRS 311.605(2). This subsection shall not apply to any proceedings or matters governed exclusively by federal law or federal regulation.

(3) Nothing in subsection (2) of this section shall be construed to restrict or limit the right to discover or use in any civil action or other administrative proceeding any evidence, document, or record which is subject to discovery independently of the proceedings of the entity to which subsection (1) of this section refers.

(4) No person who presents or offers evidence in proceedings described in subsection (2) of this section or who is a member of any entity before which such evidence is presented or offered may refuse to testify in discovery or upon a trial of any civil action as to any evidence, document, or record described in subsection (3) of this section or as to any information within his own knowledge, except as provided in subsection (5) of this section.

(5) No person shall be permitted or compelled to testify concerning his testimony or the testimony of others except that of a defendant given in any proceeding referred to in subsection (2) of this section, or as to any of his opinions formed as a result of such proceeding.

(6) In any action in which the denial, termination, or restriction of staff membership or privileges by any health care facility shall be in issue, agents, employees, or other representatives of a health care entity may with the consent of such health care entity testify concerning any evidence presented in proceedings related to the facility's denial of such staff membership or privileges.

(7) Nothing in this section shall be construed to restrict or prevent the presentation of testimony, records, findings, recommendations, evaluations, opinions, or other actions of any entity described in subsection (1) of this section, in any statutory or administrative proceeding related to the functions or duties of such entity.

(8) In addition to the foregoing, the immunity provisions of the federal Health Care Quality Improvement Act of 1986, ***Pub.L.No.*** ~~[P.L.]~~ 99-660, shall be effective arising under state laws as of July 15, 1988.

➔Section 48. KRS 311.760 is amended to read as follows:

An abortion may be performed in this state only under the following circumstances:

(1) During the first trimester of pregnancy by a woman upon herself upon the advice of a licensed physician or by a licensed physician.

(2) After the first trimester of pregnancy, except in cases of emergency to protect the

life or health of the pregnant woman, where an abortion is permitted under other provisions of KRS 311.710 to 311.820, by a duly licensed physician in a hospital ***licensed by the Cabinet for Health and Family Services***~~[duly licensed by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board]~~.

➔Section 49. KRS 314.027 is amended to read as follows:

(1) Funding for the Kentucky nursing incentive scholarship fund shall be supplied partly by funds received from penalties and fines, to include~~[,]~~ but not be limited to~~[,]~~ ~~[certificate of need]~~penalties assessed on primary care centers, hospitals, nursing facilities, and skilled and intermediate care nursing homes under the provisions of KRS 216.560 and 216B.131(2).

(2) Additional funding shall be provided by an assessment of five dollars ($5) to be added to each nurse licensure renewal application fee payable to the board, proceeds of which shall be annually allocated to the Kentucky nursing incentive scholarship fund.

(3) The board may cancel any contract between it and any applicant or recipient upon failure by the applicant or recipient to meet requirements of KRS 314.025 to 314.027 or board administrative regulations. Failure to complete the terms of the contract shall subject the applicant to legal action for the recovery of all assistance provided, together with attorney fees and interest at a compound rate of eight percent (8%) from the date of disbursement from the Kentucky nursing incentive scholarship fund.

➔Section 50. KRS 347.040 is amended to read as follows:

(1) The secretaries of the Cabinet for Health and Family Services and the Education and Workforce Development Cabinet and the chief state school officer shall jointly develop and implement a statewide plan, with adequate opportunity for public comment, to serve all persons with developmental disabilities not otherwise entitled

to and receiving the same services under another state or federal act, which will include provisions for:

(a) Identification and prompt and adequate interdisciplinary assessment;

(b) Case management services; and

(c) Services and residential alternatives as defined by this chapter in the least restrictive, individually appropriate environment.

(2) The first plan and annual updates shall be presented to the Legislative Research Commission which shall refer it to an appropriate committee for review and comment.

(3) The plan shall include:

(a) The number of institution residents on waiting lists for placement in the community;

(b) The number of persons outside institutions on waiting lists for placement in the institution;

(c) The number of persons for whom no placement is made nor services provided because of a lack of community resources;

(d) The number, type, nature, and cost of services necessary for placement to occur;

(e) The status of compliance with the plan;

(f) The cabinets' specific efforts to increase residential and institutional services and documentation of the success of these efforts; and

(g) The specific plans for new efforts to enhance the opportunities for persons with developmental disabilities to move into less restrictive environments.

~~[(4) The state health plan shall be developed consistently with the plan required under this chapter.]~~

➔Section 51. The following KRS sections are repealed:

211.9523 Abolition of category of nonemergency health transportation provider --

Conversion to disabled persons carrier or Class II ground ambulance provider.

216B.010 Legislative findings and purposes.

216B.035 Administrative staff assistance -- Records -- Oaths.

216B.040 Functions of cabinet in administering chapter -- Regulatory authority.

216B.061 Actions requiring certificates of need -- Prohibitions against dividing projects to evade expenditure minimums and against ex parte contacts -- Ambulatory surgical centers.

216B.0615 Prohibition against transferring a certificate of need -- Penalty.

216B.062 Timetable for submission of application for certificate of need to be established by administrative regulation -- Review procedure.

216B.071 Long-term care facilities for patients with Alzheimer's disease exempt from certificate of need.

216B.085 Hearing procedures -- Notification of cabinet's decisions -- Appeals.

216B.086 Revocation of certificate of need -- Hearings -- Prohibition against ex parte contacts.

216B.090 Reconsideration of cabinet's decisions.

216B.095 Nonsubstantive review of application.

216B.125 Civil action for judicial enforcement of chapter.

216B.130 Expenditure minimums or limits to be adjusted annually.

216B.180 Certificate of need not required for respite-service beds in intermediate-care facility for individuals with an intellectual disability.

216B.182 Conversion of licensed nursing home beds to licensed intermediate care facility beds between July 1, 2004, and September 1, 2005.