Uber, But For Nurses: Labor Issues Facing Nursing Facilities in the Age of COVID and the Gig Economy

Kentucky Association of Health Care Facilities 2022 Annual Meeting

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Overview

- Legal Framework and Challenges
- Legislative and Regulatory Responses
  - The Kentucky Model
  - The Minnesota/Massachusetts Model
  - Federal
- Provider Responses
- Antitrust Considerations

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New Challenges

- Health care staffing agencies are not new, but COVID-19 exacerbated existing issues
- Venture Capital/Private Equity Involvement
- AHA has observed increases in:
  - Proportional hours worked by travel staff
  - Agency rates charged
  - Agency's profit margins
- Studies have raised clinical care concerns

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Legal Framework

- Agency Agreement with Provider
  - Sets compensation rates to agency (likely silent on rates paid to staff)
  - May seek to limit provider's ability to hire agency staff directly
- Agency Agreement with Staff
  - Paid an hourly rate
  - Classified as independent contractor

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Classification Challenges

- Fair Labor Standards Act, 29 U.S.C. 201, *et seq*.
  - Sets a minimum wage (§ 206) and requires time-and-a-half for hours worked over 40 in a week, but only for "employees" (§ 207(a)-(b))
- State laws
  - Kentucky Wages and Hours Act, KRS Chapter 337

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Classification Challenges

Employees v. Independent contractors

- Employees
  - Generally, workers who are economically dependent on the business of the employer are employees
  - Most workers are employees
- Independent contractors
  - Independent contractors are workers with economic independence in business for themselves
  - Independent contractors are exempt from wage and hour laws (no overtime)

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Classification Challenges

Economic Realities Test (FLSA)

- Permanency of relationship between parties
- Degree of skill required
- Worker's investment in materials
- Worker's opportunity for profit or loss
- Degree of alleged employer's right to control manner in which work is performed
- Whether the work is an integral part of the alleged employer's business
  - *Donovan v. Brandel*, 736 F.2d 1114 (6th Cir. 1984)

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Classification Challenges

- *Walsh v. Medical Staffing of America*, 2022 U.S. Dist. LEXIS 7834 (E.D. Va. 2022)
  - Agency receives staffing requests from facilities, ID's eligible nurses, and assigns shifts
  - Nurses classified in their contract as ICs and paid "straight-time hourly for all hours worked, including for all hours worked over 40"
  - Agency retained percentage of hourly rate charged to facility
  - Declined option to track hours over 40 when designing app
  - Various documents referred to nurses as "employees"
  - Court concludes the nurses are employees of the agency; $7.2 million judgment
  - "Good faith" defense

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Other Challenges

- *Carmen v. Health Carousel, LLC*, 2021 U.S. Dist. LEXIS 113324 (S.D. Ohio 2021)
  - Agency recruits foreign nurses and offers assistance in visa/immigration process
  - Contracts based on "regular-time work hours" and contained significant liquidated damages and noncompete clauses
  - Employee handbook contained "no gossiping provisions"
  - Alleged violations of the Trafficking Victims Protection Act
- *Paguirigan v. Prompt Nursing Employment Agency*, 827 Fed. Appx. 116
  - TVPA lawsuit in which liquidated damages clause was held unenforceable
  - Final judgment for $1.56 million included violations of TVPA and failure to pay prevailing wage

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State Legislative Actions

- Kentucky
  - House Bill 282 passes in Spring 2022
  - CHFS promulgates implementing regulation in August 2022
  - Registration and oversight model, with restrictions on operations/contracts
  - Revision of KRS 367.374 (anti-price gouging statute)

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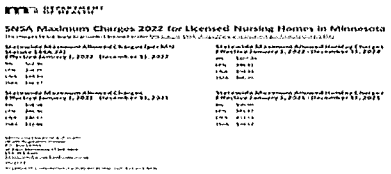
State Legislative Actions

- Minnesota/Massachusetts
  - Adopted prior to COVID-19
  - Registration and oversight PLUS pay caps



SNSA Maximum Charges 2022 for Licensed Nursing Homes in Minnesota

  - Affirmative quality of care duties

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Federal Actions

- Sens. Kelly/Cassidy letter to White House
  - Urged administrative action under existing laws to evaluate "extreme" and "vastly inflated prices" for potential price gouging
- Travel Nurse Agency Transparency Act
  - Mandates a GAO study, but no new enforcement mechanisms
- COVID-19 Price Gouging Prevention Act
- Heroes Act

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Federal Actions

- Department of Labor's Proposed Rulemaking
  - 87 Fed. Reg. 62218 (Oct. 13, 2022)
  - Revises the standards for determining how workers are classified under FLSA
  - Not specific to staffing agencies, but expected to impact all "gig economy" operations
  - Comments due on or before November 28, 2022

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Provider Responses

- Re-Negotiating Facility-Agency Agreements
  - "Change in the law" clauses
  - Representations and warranties re: HB 282 compliance
  - Access to records
  - Non-solicitation
  - Removal/revision of liquidated damages clauses
  - Termination

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Provider Responses

- Price Gouging
  - State/federal state of emergency
  - "Grossly in excess"—more than 10% of "price prior to declaration"
  - New costs and increases in existing costs
  - Complaints with OAG's Office of Consumer Protection
  - Private right of action?
  - Dormant commerce clause challenge—*Online Merchants' Guild v. Cameron*, 995 F.3d 540 (6th Cir. 2021)

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Provider Responses

- *Steward Healthcare Sys., LLC v. Aya Healthcare Inc.*, 2021 Mass. Super. LEXIS 59 (March 2021)
  - Payment dispute between hospital system and agency
  - Agency instructed clinicians to not show up for assignments
  - Steward obtains an injunction but ordered to post a $10 million bond

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Antitrust

- Sherman Act and Clayton Act
- Consolidation and Trade Organization Advocacy
- DOJ/FTC Statement Regarding COVID-19 and Competition in Labor Markets

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Antitrust

- DOJ/FTC Guidance:
  - Antitrust Guidelines for Collaborations Among Competitors
  - Antitrust Guidance for Human Resources Professionals
  - Statements of Antitrust Enforcement Policy in Healthcare
- Acknowledges the usefulness of collaboration within certain boundaries

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Antitrust

- No-poach agreements—*Seaman v. Duke University*, 2019 U.S. Dist. LEXIS 163811 (M.D. N.C. 2019)
- Group boycotts—*In re Debes Corp.*, 1992 F.T.C. LEXIS 202 (F.T.C 1992)
- Wage Fixing—*Cason-Merena v. Detroit Med. Ctr.*, 862 F.Supp.2d 603 (E.D. Mich. 2012)
- Quality of Care/Professional Governance—*Nat'l Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978)

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Questions? Comments?

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Uber, But for Nurses: Recent Legal Issues Related to Health Care Staffing Platforms

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The rise of "gig economy" web-based applications over the past several years has transformed American society, in ways both positive and negative. Uber and Lyft made it easier and cheaper to hail a ride, but increased vehicle traffic and hampered efforts to expand public transportation.[1] Airbnb encouraged travelers to "live like a local" and homeowners to make extra cash from their spare rooms, but raised local housing costs in the process.[2]

Further, many of these services rely on regulatory arbitrage as a core of their business model. They have bet, frequently correctly, that government regulators will likely be slow to apply existing laws to new presentations of old ideas, especially when those presentations are hailed as "innovative" or "disruptive" by tech entrepreneurs and innovators. For instance, Uber and others long maintained that the drivers and other individuals who actually provide services to consumers are independent contractors and not employees, a contention that has been challenged in several lawsuits[3] and resulted in large settlements in some instances.[4] Critics of Airbnb have contended

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[1] Mi Dao, Hui Kong, and Jinhua Zhao, *Impacts of Transportation Network Companies on Urban Mobility*, 4 Nature Sustainability 494-500, February 1, 2021 (available at https://doi.org/10.1038/s41893-020-00678-z).

[2] Josh Bivens, *The Economic Costs and Benefits of Airbnb*, Economic Policy Institute, January 30, 2019 (available at epi.org/157766).

[3] Margot Roosevelt and Suhauna Hussain, *Prop. 22 is Ruled Unconstitutional, a Blow to California Gig Economy Law*, Los Angeles Times, August 20, 2021 (available at https://www.latimes.com/business/story/2021-08-20/prop-22-unconstitutional).

[4] Julia Carrie Wong, *Uber Reaches $100m Settlement in Fight With Drivers, Who Will Stay Contractors*, The Guardian, April 21, 2016 (available at https://www.theguardian.com/technology/2016/apr/21/uber-driver-settlement-labor-dispute-california-massachusetts); *see also* Erin Mulvaney, *Uber Will Pay $8.4 Million to End Years-Long Driver Class Action*, Bloomberg Law, Feb. 18, 2022 (available at https://news.bloomberglaw.com/daily-labor-report/uber-will-pay-8-4-million-to-end-years-long-driver-class-action).

that the service skirts tax and hotel laws, which has resulted in localities promulgating new regulations.[5]

What happens when some of the same concepts that undergird the services Americans increasingly rely upon to travel are applied to the health care industry? While health care staffing agencies (and their use of app-based platforms) are not new, their use exploded as a result of the COVID-19 global pandemic. Health care facilities found themselves suddenly inundated with infectious, medically complex patients and scrambling to fill positions opened by staff illnesses, increasing their reliance on temporary staff and leading them to pay the higher wages that these staff members can command.

Whether this is a positive development depends upon who you ask. In connection with a press release touting its securing of $76 million in financing, connectRN described itself as a "tech-enabled platform connecting nurses and aides with opportunities to improve their work life."[6] Similarly, NurseShifts touted itself as enabling "healthcare facilities to manage schedules and provide shifts more successfully than ever before" while also "[d]ecreasing work overload and burnout" and "empowering healthcare professionals to take back their freedom and control of their own lives."[7] Workers who have utilized these services sometimes report less positive experiences—as in the case of Uber, practitioners have challenged agencies' classification of them

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[5] *Hosts With Multiple Units—A Key Driver of Airbnb Growth*, American Hotel & Lodging Association, March 2017 (available at https://www.ahla.com/sites/default/files/CBRE_AirbnbStudy_2017.pdf).

[6] *connectRN Closes $76M Financing to Support Accelerating Growth of Healthcare Workforce Platform*, BusinessWire, December 8, 2021 (available at https://www.businesswire.com/news/home/20211208005341/en/connectRN-Closes-76M-Financing-to-Support-Accelerating-Growth-of-Healthcare-Workforce-Platform).

[7] *StaffHealth.com Launches Mobile App for Fast & Efficient Nurse Staffing*, PRNewswire, May 17, 2022 (available at https://www.prnewswire.com/news-releases/staffhealthcom-launches-mobile-app-for-fast--efficient-nurse-staffing-301549146.html).

as independent contractors;[8] more disturbingly, in at least one instance practitioners have accused an agency of human trafficking in addition to high quitting fees and low payments relative to permanent employees.[9] Health care providers have reported "soaring prices," leading to "heavy margins" for the agency. The American Hospital Association commissioned research on the growing impact of health care staffing platforms during COVID-19. The hours worked by travel nurses as a percentage of total hours worked by nurses in hospitals went from 4% in January 29 to 23% in January 2022, resulting in hospitals increasing their spending on nurse labor expenses with travel nurses from 5% to 40%. During the same time period, the AHA reported that the rates charged by health care staffing agencies increased by 213%, while the agencies' margin increased from 15% to 62%.[10] Beyond the bottom line, facilities are also concerned about quality of care issues that may result from heavy turnover in nursing staff; a pre-pandemic study found that "[h]eavy reliance on temporary staff is associated with higher risk for patients dying."[11]

I. The Legal Framework for Health Care Staffing Platforms.

The specific operation of health care staffing platforms varies from platform to platform, and from provider to provider. The typical arrangement involves the staffing platform entering into agreements with licensed practitioners on one side of the arrangement and with health care

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[8] *Chafen Suttle, et al. v. Care.Stat! Inc. d/b/a CareRev, et al.*, Superior Court of Califorina for the County of Santa Clara, Case No. 21CV383162 (Complaint filed on June 17, 2021).

[9] Kaitlin Schroeder, *Southwest Ohio Health Staffing Company Accused of Labor Trafficking in Lawsuit*, Dayton Daily News, Feb. 14, 2022 (available at https://www.daytondailynews.com/local/southwest-ohio-health-staffing-company-accused-of-labor-trafficking-in-lawsuit/WQK7P75CMZDWPG4FRBOQEF24DQ/).

[10] Letter from Stacey Hughes, Executive Vice President, to Rep. Gregory Murphy and Rep. Marianette Miller-Meeks, July 28, 2022 (available at https://www.aha.org/lettercomment/2022-07-28-aha-voices-support-travel-nursing-agency-transparency-study-act).

[11] Chris Dall'Ora, Antonello Maruotti, and Peter Griffiths, *Temporary Staffing and Patient Death in Acute Care Hospitals: A Retrospective Longitudinal Study*, Journal of Nursing Scholarship, Vol. 52, Iss. 2, December 10, 2019 (available at https://sigmapubs.onlinelibrary.wiley.com/doi/full/10.1111/jnu.12537).

facilities on the other. The compensation to be paid is negotiated by and between the agency and the facility, with the agency paying a percentage of the payment it receives from the facility to the licensed practitioner assigned to work with the facility. Then, the typical agreement between an agency and licensed practitioner will seek for the practitioner to be classified as an independent contractor, rather than as an employee of the agency. One benefit of this classification to the agencies is that independent contractors are typically not subject to wage and hour restrictions that could result in more money being owed to the practitioner.

As we will see, the federal government has enacted new laws in response to the increased prevalence in health care staffing services, but the Department of Justice has taken action to hold staffing agencies liable for misclassification of staff in ways that violate federal labor laws. The Fair Labor Standards Act requires certain employees to pay time-and-a-half to employers, but not independent contractors, for hours worked in excess of 40 hours in one week.[12]

In *Walsh v. Medical Staffing of America*, the Department of Justice won a judgment requiring a Virginia staffing agency to pay over $7.2 million in back wages and liquidated damages based on its willful misclassification of temporary nursing staff.[13] The court recited the six-factor federal test for classifying employees under the Fair Labor Standards Act, which considers:

- The degree of control that the putative employer has over the manner in which the work is performed;
- The worker's opportunity for profit and loss dependent on managerial skill;
- The worker's investment in equipment or material, or his employment of other workers;
- The degree of skill required for the work;

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12 29 U.S.C. § 207(a)(1); *see also Rutherford Food Corp. v. McComb*, 331 U.S. 722, 729 (1947).

13 *Walsh v. Medical Staffing of Am., LLC*, 2022 U.S. Dist. LEXIS 7834 (E.D. Va. 2022).

- The permanence of the working relationship; and
- The degree to which the services rendered are an integral part of the putative employer's business.[14]

The court concluded that Steadfast, the staffing agency, had a high degree of control over the nurses' manner of work—this included scheduling and assigning; investments in training and insurance; setting the nurses' pay rate; tracking hours; and supervising and disciplining the nurses—indicating that Steadfast was an employer for purposes of federal law.[15] Similarly, the court concluded that the remaining factors also pointed to the same conclusion—Steadfast utilized a non-compete provision; the relationship between Steadfast and the nurses was, in practice, intended to be permanent rather than term-limited; and they had no opportunity for profit or loss.[16]

Carmen v. Health Carousel, LLC, an ongoing case pending in the Southern District of Ohio, highlights the unique (and disturbing) issues that can arise in these cases.[17] The defendant staffing agency recruited foreign nurses to work in its client facilities in part by assisting the nurses in the visa and immigration process, including by providing housing.[18] The agency's contracts provided a "commitment period" that was based upon "regular-time work hours,"—in other words, it was calculated in such a way that overtime hours did not count—as well as liquidated damages and noncompete clauses.[19] The company also required employees to vacate agency-provided

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14 *Id.*, at *23 (citing *McFeely v. Jackson St. Entm't, LLC*, 825 F.3d 235, 241 (4th Cir. 2016)).

15 *Id.*, at *27-35.

16 *Id.*, at *35-36.

17 *Carmen v. Health Carousel, LLC*, 2021 U.S. Dist. LEXIS 113324 (S.D. Ohio 2021).

18 *Id.* at *3.

19 *Id.* at *4.

housing within 48 hours of an alleged breach and required employees to adhere to an employee handbook that contained a "no gossiping" provision, arguably isolating employees from one another. The plaintiffs alleged that this arrangement, taken as a whole, violated the federal Trafficking Victims Protection Act and an analogous state law by threatening legal consequences and non-physical harm, compelling them wo provide services against their will.[20] The defendant agency filed a motion to dismiss, arguing that trafficking cannot occur by definition if the employee voluntarily entered into the contractual arrangements. The court disagreed, noting the existence of one-sided, egregious contract exit terms that compel reasonable people "to remain in a position out of a fear of the consequences that will follow if" he or she leaves.[21] The court made similar comments about the liquidated damages provision, which it concluded could constitute the requisite showing of "serious harm" under the federal law.[22] In the end, the court concluded that the Plaintiffs' complaint made a showing of both procedural and substantive unconscionability such that dismissal was inappropriate before discovery could occur.[23]

II. Legislative and Regulatory Responses.

a. Kentucky

In the spring of 2022, the General Assembly considered and passed House Bill 282, which Governor Beshear signed into law on April 8, 2022.[24] On August 4, 2022, the Cabinet for Health

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20 *Id.* at 16.

21 *Id.* at 20.

22 *Id.* at 23.

23 *Id.* at 27-29.

24 The full text of House Bill 282 is attached hereto for convenience, but these materials will reference the codified version of the bill's text.

and Family Services gave public notice of a set of regulations intended to implement HB 282.[25] These authorities generally adopt a registration model whereby the operations of health care staffing agencies are subject to the Cabinet's oversight and place services provided by these agencies within the ambit of existing price gouging laws. Other states, including Maryland and Indiana, have introduced legislation taking a similar approach.

Health care services agencies must register with the Kentucky Cabinet for Health and Family Services prior to operating or advertising in Kentucky.[26] Information that must be provided in the registration process includes the identification and address of "controlling person[s]," i.e., business entities and individuals who have ownership interests in the agency or who direct the agency's operation, proof of compliance with the terms of HB 282, a policy and procedure describing how the agency's records will be immediately available to the Cabinet upon request, and a registration fee of $3,000.00 for each location of the agency.[27] HB 282 permits the Cabinet to designate "other relevant information...necessary to properly evaluate an application for registration."[28] Each registration is effective for a year, but a change in controlling person, management, or ownership results in the registration being voided and the need for a new application.[29]

HB 282 places minimum operational requirements on health care staffing agencies. These include the retention of documentation that the agency's direct care staff meet minimum licensing, certification, training, and continuing education standards; meet health and other qualification

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25 The proposed text of 906 KAR 1:210 is attached hereto for convenience.

26 *See* KRS 216.720(1).

27 *See id.* at (2)(a)-(f); *see also* KRS 216B.718(3) (defining "controlling person").

28 *See id.* at (2)(e).

29 *See id.* at (4).

requirements for personnel placed with assisted living communities, long-term care facilities, and hospitals; maintenance of professional and general liability insurance; maintenance of an "employee dishonesty bond" of $10,000; maintenance of workers' compensation insurance for direct care staff; and retention of records for five years, which must be made available immediately on request.[30]

HB 282 restricts certain business practices of health care services agencies that providers have argued exacerbated the staffing shortage that worsened during COVID, and that individual practitioners have found to be used against them by the agencies. Agencies may not "[r]estrict in any manner the employment opportunities of any direct care staff," and may not utilize "contract buy-out provisions or contract non-compete clauses."[31] In agency contracts with individual practitioners and health care facilities, agencies may not require the payment of liquidated damages or other compensation if an individual practitioner is hired as a permanent employee of a facility; this is permissible only if the compensation is payable by the facility and is subject to a pro-rata deduction based on the amount of time the individual practitioner is on the agency's payroll.[32] Agencies also may not solicit current staff of health care facilities or require individual practitioners to recruit new employees as a condition of employment.[33] Contracts failing to meet these requirements are deemed to be unfair trade practices and are void on their face.[34]

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30 *See* KRS 216.722(1)(a)-(f).

31 KRS 216.274(1)(a).

32 *Id.* at (b).

33 *Id.* at (c).

34 *Id.* at (2); *see also* KRS 365.060. As an unfair trade practice, a contract violating this provision also subjects the agency to treble damages and injunctive relief pursuant to KRS 365.070(1).

HB 282 obligates health care services agencies to submit quarterly reports to the Cabinet detailing the assignments of direct care staff to health care facilities and copies of invoices submitted to, and proof of payment by, long-term care facilities and hospitals.[35] In the event of an investigation by the Attorney General for an unfair trade practice, the agency must be prepare to disclose amounts charged by the agency, amounts actually paid to direct care staff, and any other information the Attorney General deems relevant to the agency's charges.[36] However, nothing in HB 282 governs an agency's charges or the amounts that are actually paid to direct care staff.

HB 282 amends existing consumer protection statutes to make them applicable to health care services agencies. Direct care staff services are now an item that has been expressly added to Kentucky's anti-price gouging statute.[37]

Finally, HB 282 also contains enforcement mechanisms. Failure to comply with minimum requirements will result in a denial of the initial application; if the failure is by an existing and registered agency, the agency will be assessed a monetary penalty of $25,000.00 and its license will be revoked.[38] An agency's knowing placement of a direct care staff person with an assisted living community, long-term care facility, or hospital, where the individual illegally or fraudulently obtained a diploma, license, certification, or background check will result in the Cabinet revoking the agency's registration.[39]

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35 KRS 216.728(1) and (2)(a)-(c).

36 *See id.* at (3).

37 *See* KRS 367.374(1)(b)(10).

38 *See* KRS 216.722(2)(a)-(b).

39 *See id.* at (3). This is a narrow limitation, given that the agency is not responsible for reckless or negligent placement of such individuals, or for the knowing, reckless, or negligent placement of individuals who do not meet minimum requirements to perform the job they are employed to provide.

b. Other States

Several other states have passed or proposed legislation aimed at regulating health care staffing agencies and have utilized models that in some cases differ from Kentucky's registration and oversight model, including capping the rates that staffing agencies may charge. Minnesota and Massachusetts had such laws on the books prior to the pandemic, and other states, including Ohio and Pennsylvania, are considering legislation that would do the same.

Minnesota enacted laws prior to the COVID-19 pandemic regulating the operations of "supplemental nursing services agencies."[40] Similar to Kentucky's HB 282, Minnesota law requires these agencies to register with the Commissioner of the Minnesota Department of Public Health, sets minimum operational requirements for the agencies, and permits investigation of the agencies by state officials.[41] However, Minnesota's law goes further than Kentucky and places limitations on the rates that agencies may charge nursing facilities. It limits agency's charges to an amount of no more than 150% of "the sum of the weighted average wage rate, plus a factor [incorporating payroll taxes] for the applicable employee classification for the geographic group."[42] For 2022, the statewide maximum allowed charge was $62.36 for a registered nurse; $50.75 for a licensed practical nurse; $34.10 for a certified nurse assistant; and $36.57 for a trained medication assistant.[43]

Similarly, Massachusetts law regulates "temporary nurse staffing agencies" by requiring them to register with the state and imposing minimum personnel and operational requirements. It

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40 Minn. Stat. 144A.70, *et seq.*

41 *See* Minn. Stat. 144A.71-73.

42 Minn. Stat. 144A.174.

43 Minnesota Department of Health, SNSA Maximum Charges 2022 for Licensed Nursing Homes in Minnesota, May 2022 (available at https://www.health.state.mn.us/facilities/regulation/snsa/docs/snsa.pdf).

also contains measures that should address quality of care concerns—Massachusetts law requires the agencies to develop written procedures for assignments and to conduct annual performance reviews of its personnel and of the agency itself.[44] It also requires agencies to notify the state's nursing board of "poor nursing practice," including failure to adhere to nursing standards of conduct or engaging in conduct that would subject the nurses' licenses to disciplinary action.[45] Finally, Massachusetts law caps the rates that these agencies may charge; the rates differ based on the qualifications of the nurse, the work assignment (i.e., hospital or nursing facility), and the geographic area of the state.[46]

c. Federal

The United States Congress has not enacted legislation seeking to regulate health care staffing agencies on a nationwide basis, but legislators have raised concerns to, and introduced federal draft legislation that would require, federal administrative agencies to provide additional oversight of health care staffing agencies.

In November 2021, a group of legislators including Senators Mark Kelly and Bill Cassidy, sent a letter to Jeffrey Zients, the Biden Administration's COVID-19 Response Team Coordinator, asking the administration to investigate "price gouging" by health care staffing agencies.[47] The letter discussed the significant strain that COVID-19 put on the nation's health care infrastructure, including the fact that health care employment decreased by 17,500 positions in September 2021 alone. The legislators reported hearing about "extreme" or "vastly inflated" prices and high

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44 105 C.M.R. §§ 157.400, 157.500, and 157.510.

45 105 C.M.R. § 157.600.

46 101 C.M.R. § 345.03.

47 *White House Urged to Investigate Price Gouging by Staffing Agencies*, American Hospital Association, November 15, 2021 (available at https://www.aha.org/2021-11-15-white-house-urged-investigate-price-gouging-staffing-agencies).

margins "for nurse staffing agencies from hospitals in [their] states," which raised the concern that some agencies "may be taking advantage to increase their profits at the expense of patients and the hospitals that treat them." They requested that the White House take action to determine whether these conditions are the result of anticompetitive activity, whether there is evidence of collusion or anti-competitive pricing, whether higher rates translated to higher pay for the actual practitioners, to what extent these agencies aree being paid by COVID-19 relief funds, and what impact these agencies are having in rural and underserved communities.

In June 2022, Senator Kevin Cramer introduced the Travel Nurse Agency Transparency Act. If passed, this measure would require the Government Accountability Office to study the effects health care staffing agencies on the health care industry during the COVID-19 pandemic. The study would be specifically empowered to look into potential price gouging, the difference between the agencies' charges and their payments to practitioners, whether state impositions of pay caps were affected by the market reaction to same, whether agency practices have contributed to workforce shortages, and the effect of private equity acquisitions on agency profits.[48] The American Hospital Association has come out in favor of this bill, stating that the bill will highlight the "significant financial and operational concerns as a result of the unsustainable rates charged by travel nurse staffing agencies."[49]

III. Responses by Providers.

a. Lawsuits.

Providers have utilized the court system to address what they consider to be impermissible conduct by health care staffing agencies. One case out of Massachusetts highlights the high stakes

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48 Travel Nursing Agency Transparency Study Act of 2022, S. 4352, 117th Congress (2021-2022).

49 *See* n. 11, *supra.*

and hardball tactics that sometimes emerge between providers and staffing agencies. Steward Health Care System, a multi-state and multi-regional hospital system, filed suit against Aya Healthcare, a travel nurse staffing agency, in March of 2021. Steward accumulated approximately $40 million in unpaid invoices to Aya but contended that Aya had overcharged and inflated costs—its hourly rates had been around $75 prior to the COVID pandemic but increased to around $160, Steward alleged, in violation of the Massachusetts state law discussed above.[50] Eventually, Aya instructed clinicians who it had placed in Steward facilities "not to show up for their assignments" in response to Steward's failure to pay invoices totaling over $40 million and instructed cardiac catheterization personnel to leave a Steward hospital, forcing the hospital to cancel procedures.[51] Steward sought and obtained an injunction to prohibit this conduct by Aya, with the court finding that Steward was "very likely to succeed on its claim that" Aya had breached its contract by instructing clinicians to cease work.[52] However, the court further required Steward to post a $10 million bond to offset the potential risk to Aya of continuing to provide clinicians at Steward facilities. This case highlights the high stakes and

b. <u>Antitrust Considerations.</u>

In the past several years, there has been a trend toward consolidation within the health care industry, with hospitals, long-term care facilities, and other providers going under corporate umbrellas. In addition, industry groups like the Kentucky Hospital Association and the Kentucky Association of Health Care Facilities bring together unrelated providers to discuss challenges that

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50 Melanie Evans and Jim Carlton, *Soaring Costs of Nurses During Covid-19 Pandemic Are at Center of Lawsuits*, Wall Street Journal, April 8, 2021 (available at https://www.wsj.com/articles/soaring-costs-of-nurses-during-covid-19-pandemic-are-at-center-of-lawsuits-11617914600).

51 *Steward Health Care Sys., LLC v. Aya Healthcare, Inc.*, 2021 Mass. Super. LEXIS 59, *1-2 (March 8, 2021).

52 *Id.* at *6-7.

face the industry and to assist in education and advocacy efforts. These industry groups have publicly encouraged federal and state governments to investigate and regulate health care staffing agencies as part of their advocacy work. However, it is important that such efforts remain within the bounds of federal antitrust law.

Generally, the Sherman Act provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."[53] Price fixing among competitors has long been recognized as such a potentially damaging and anti-competitive restraint on trade that it is unlawful *per se*, meaning that proof of the activity's anti-competitive effect on the market or the intent of the individuals involved is not required in order to prove a violation. Early in the pandemic, the Department of Justice and Federal Trade Commission expressed that while "there are many permissible ways that firms can engage in procompetitive collaboration, COVID-19 does not provide a reason to tolerate anticompetitive conduct that harms" health care workers, whether that conduct was by "employers, staffing companies (including medical travel and locum agencies), [or] recruiters."[54]

A pre-pandemic case highlights the issues that can emerge when ostensible competitors in the health care industry communicate about issues they have in common. In *Cason-Merenda v. Detroit Med. Ctr.*, a class of plaintiffs consisting of registered nurses filed a lawsuit alleging that eight Detroit-area hospitals conspired among themselves and with other local hospitals to suppress nurses' wages by "exchanging compensation-related information."[55] These efforts included the

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[53] 15 U.S.C. § 1.

[54] Department of Justice and Federal Trade Commission, *Joint Antitrust Statement Regarding COVID-19 and Competition in Labor Markets*, April 2020 (available at https://www.justice.gov/opa/press-release/file/1268506/download).

[55] *Cason-Merenda v. Detroit Med. Ctr.*, 862 F.Supp.2d 603, 606 (E.D. Mich. 2012).

hospitals' participation in quarterly local surveys of current compensation paid to nurses; the hospitals' provision of unmasked, named data used in ostensibly blind third-party surveys to one another; the hospitals' human resources and compensation staff maintained contact lists of their counterparts at other facilities that witnesses testified were used for *quid pro quo* exchanges of information; and the participation of hospitals' employees in industry organizations, including one at which "bidding wars" that caused nurses to "go down the street for [ten cents an hour]" were discussed.[56] These discussions were not limited to historical information; the defendants also exchanged information regarding "projected future wage increase," a practice that the DOJ/FTC guidance has indicated is "very likely to be considered anticompetitive."[57]

Though their enforcement activity indicate the seriousness with which the Department of Justice and Federal Trade Comission view this type of conduct, they have also long acknowledged that, "[i]n order to compete in modern markets, competitors sometimes need to collaborate," going so far as to publish guidance for collaborations among competitors[58] and guidance for human resources professionals.[59] These documents give insight into what the relevant federal regulators believe to be low-risk and high-risk behavior with regard to antitrust. While information exchanges regarding wages between competitors may raise suspicions, such exchanges may be lawful under certain circumstances, including where:

- A neutral third party manages the exchange;

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[56] *Id.*, at 607-615.

[57] *Id.* at 631 (emphasis added); *see also* DOJ/FTC's *Antitrust Guidelines for Collaborations Among Competitors*, *infra.* ("[T]he sharing of information on current operating and future business plans is more likely to raise concerns than the sharing of historical information.").

[58] Federal Trade Commission and Department of Justice, *Antitrust Guidelines for Collaborations Among Competitors*, April 2000 (available at https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf).

[59] Federal Trade Commission and Department of Justice, *Antitrust Guidance for Human Resource Professionals*, October 2016 (available at https://www.justice.gov/atr/file/903511/download).

- The information being exchanged is historical, rather than current or projected;

- The information is aggregated to protect the identity of the underlying sources; and

- Enough sources are aggregated such that it is not possible to link particular data to an individual source.[60]

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60 *Id.*

CHAPTER 110

(HB 282)

AN ACT relating to health care services agencies.

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

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 216 IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 6 of this Act:

(1) "Assisted-living community" has the same meaning as in KRS 194A.700;

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

(3) "Controlling person" means:

(a) A corporation, partnership, or other business entity, or an officer, program administrator or director thereof, whose responsibilities include the direction of the management or policies of a health care services agency; or

(b) An individual who, directly or indirectly, beneficially owns an interest in a corporation, partnership, or other business entity that is a health care services agency;

(4) "Direct care service" means a service provided to a resident in an assisted-living community, a resident in a long-term care facility, or a patient in a hospital, by direct care staff;

(5) "Direct care staff" means an individual who contracts with or is employed by a health care services agency to provide direct care services to residents in assisted-living communities, residents in long-term care facilities, or patients in hospitals;

(6) "Health care services agency" means any person, firm, corporation, partnership, or other business entity engaged in the business of referring direct care staff to render temporary direct care services to an assisted-living community, a long-term care facility, or a hospital but does not include a health care services agency operated by an assisted-living community, a long-term care facility, a hospital, or any affiliates thereof, solely for the purpose of procuring, furnishing, or referring temporary or permanent direct care staff for employment at that assisted-living community, long-term care facility, hospital, or any affiliates thereof;

(7) "Hospital" means a facility licensed pursuant to KRS Chapter 216B as an acute-care hospital, psychiatric hospital, rehabilitation hospital, or chemical dependency treatment facility; and

(8) "Long-term care facilities" has the same meaning as in KRS 216.510.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 216 IS CREATED TO READ AS FOLLOWS:

(1) No health care services agency shall be operated, maintained, or advertised without registering with the Cabinet for Health and Family Services. Each separate location of a health care services agency shall register and obtain a separate registration.

(2) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish the application process for health care services agency registration. The application shall include:

(a) The names and addresses of any controlling person;

(b) The names and addresses of any owner who does not meet the definition of controlling person. If the owner is a corporation, the application shall include copies of its articles of incorporation and current bylaws, and the names and addresses of its officers and directors;

(c) Satisfactory proof of compliance with Sections 1 to 6 of this Act;

(d) A policy and procedure that describes how the health care services agency's records will be immediately available to the cabinet upon request;

(e) Any other relevant information that the cabinet determines is necessary to properly evaluate an application for registration; and

(f) A registration fee in the amount of three thousand dollars ($3,000) per registration.

(3) The cabinet shall deny any application for health care services agency registration for failure to provide the information required by this section.

(4) A registration issued by the cabinet to a health care services agency shall be effective for a period of one (1) year from the date of its issuance unless the registration is revoked for noncompliance with Sections 1 to 6 of this Act. If a controlling person changes, the health care services agency is sold, or management is transferred, the registration of the agency shall be voided and the new controlling person, owner, or manager may apply for a new registration.

(5) The cabinet shall not issue or renew a health care services agency registration if a controlling person's registration has not been renewed or has been revoked due to noncompliance with requirements in Sections 1 to 6 of this Act for five (5) years from the date of nonrenewal or revocation.

(6) A health care services agency may request a hearing in accordance with KRS Chapter 13B to appeal a denial of an application for registration, revocation of registration, or an imposed monetary penalty.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 216 IS CREATED TO READ AS FOLLOWS:

(1) A health care services agency shall:

(a) Retain documentation that each direct care staff contracted with or employed by the agency meets the minimum licensing, certification, training, and continuing education standards for his or her position;

(b) Comply with all pertinent requirements relating to the health and other qualifications of personnel employed in assisted-living communities, long-term care facilities, or hospitals;

(c) Carry all professional and general liability insurance coverage to insure against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in the provision of direct care services by the health care services agency or any direct care staff;

(d)_ Carry an employee dishonesty bond in the amount of ten thousand dollars ($10,000);

(e) Maintain coverage for workers' compensation for all direct care staff; and

(f) Retain all records for five (5) calendar years and make all records immediately available to the cabinet upon request.

(2) Failure to comply with subsection (1) of this section shall result in:

(a) Denial of an application for registration or registration renewal; or

(b) Revocation of registration and a monetary penalty in the amount of twenty-five thousand dollars ($25,000).

(3) If the cabinet determines that a health care services agency has knowingly provided to an assisted-living community, a long-term care facility, or a hospital direct care staff who have illegally or fraudulently obtained or been issued a diploma, registration, license, certification, or criminal background check, the cabinet shall immediately notify the agency that its registration will be revoked in fifteen (15) days.

➔SECTION 4. A NEW SECTION OF KRS CHAPTER 216 IS CREATED TO READ AS FOLLOWS:

(1) A health care services agency shall not:

(a) Restrict in any manner the employment opportunities of any direct care staff that is contracted with or employed by the agency including but not limited to contract buy-out provisions or contract non-compete clauses;

(b) Require, in any contract with direct care staff, an assisted-living community, a long-term care facility, or a hospital, the payment of liquidated damages, employment fees, or other compensation should the employee be hired as a permanent employee of the assisted-living community, long-term care facility, or hospital except in cases where the damages, fees, or compensation are payable, solely by the assisted-living community, long-term care facility, or hospital and the contract with the assisted-living community, long-term care facility, or hospital specifies that the amount will be reduced pro-rata based on the length of time the direct care staff performs services for the assisted-living community, long-term care facility, or hospital while on the payroll of the health care services agency; or

(c) Solicit or recruit the current staff of an assisted-living community, long-term care facility, or hospital, or require, as a condition of employment, assignment, or referral, that their employees recruit new employees for the agency from among the current employees of the assisted-living community, long-term care facility, or hospital to which the agency employees are employed, assigned, or referred.

(2) Any contract between a health care services agency and direct care staff that does not comply with subsection (1) of this section shall be considered an unfair trade practice and be void pursuant to KRS 365.060.

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 216 IS CREATED TO READ AS FOLLOWS:

The cabinet shall establish a reporting system for complaints relating to a health care services agency or direct care staff. Complaints may be reported by any member of the public. The cabinet shall investigate the complaints and report its findings to the complaining party and the health care services agency.

➔SECTION 6. A NEW SECTION OF KRS CHAPTER 216 IS CREATED TO READ AS FOLLOWS:

(1) A health care services agency shall submit quarterly reports to the cabinet.

(2) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish requirements for health care services agencies to submit quarterly reports. The quarterly reports shall include but not be limited to the following:

(a) The name, professional licensure or certification, and assigned location for each direct care staff;

(b) The length of time the direct care staff have been assigned to the assisted-living communities, long-term care facilities, or hospitals and the total hours worked; and

(c) For all long-term care facilities or hospitals that participate in the Medicare and Medicaid programs, copies of all invoices submitted to the long-term care community or hospital and proof of payment by the long-term care community or hospital.

(3) A health care services agency shall disclose the following information in response to a request from the Attorney General during an investigation of an alleged or suspected violation of Section 7 of this Act by the health care services agency:

(a) The amount charged for each direct care staff;

(b) The amount paid to each direct care staff;

(c) The amount of payment received that is retained by the health care services agency; and

(d) Any other information that the Attorney General deems relevant to determine the amount that the assisted-living facility, long-term care facility, or hospital is charged by the health care services agency.

(4) The information provided under subsection (3) of this section shall not be subject to open records laws pursuant to KRS 61.870 to 61.884.

➔Section 7. KRS 367.374 is amended to read as follows:

(1) (a) When a Condition Red has been declared by the United States Department of Homeland Security under the Homeland Security Advisory System, *the Secretary of the Department of Health and Human Services, under Section 319 of the Public Health Service Act, declares a public health emergency,* or the Governor has declared a state of emergency under KRS 39A.100, the Governor may implement this section by executive order for a period of fifteen (15) days from notification of implementation, as required by KRS 367.376. The order implementing this section shall be limited to the geographical area indicated in the declaration of emergency. The Governor may terminate or limit the scope of the order at any time.

(b) No person shall sell, rent, or offer to sell or rent, regardless of whether an actual sale or rental occurs, a good or service listed in this paragraph or any repair or reconstruction service for a price which is grossly in excess of the price prior to the declaration and unrelated to any increased cost to the seller. Goods and services to which this section applies are:

1. Consumer food items;

2. Goods or services used for emergency cleanup;

3. Emergency supplies;

4. Medical supplies;

5. Home heating oil;

6. Building materials;

7. Housing;

8. Transportation, freight, and storage services; ~~[and]~~

9. Gasoline or other motor fuels*; and*

10. Direct care staff services provided by a health care services agency as defined in Section 1 of this Act.

(c) A person's price does not violate this subsection if it is:

1. Related to an additional cost imposed by a supplier of a good or other costs of providing the good or service, including an additional cost for labor or materials used to provide a service;

2. Ten percent (10%) or less above the price prior to the declaration;

3. Ten percent (10%) or less above the sum of the person's costs and normal markup for a good or service;

4. Generally consistent with fluctuations in applicable commodity, regional, national, or international markets, or seasonal fluctuations; or

5. A contract price, or the result of a price formula, established prior to the order implementing this subsection.

(d) Whether a price violates this subsection is a question of law. In determining if a violation of this subsection has occurred, the court shall consider all relevant circumstances, including prices prevailing in the locality at that time.

(2) The provisions of this section may be extended for up to three (3) additional fifteen (15) day periods by the Governor, if necessary to protect the lives, property, or welfare of the citizens.

(3) If a person sold or rented a good or service listed in subsection (1) of this section at a reduced price in the thirty (30) days prior to the Governor's implementation of this section, the price at which that person usually sells or rents the good or service in the area for which the declaration was issued shall be used in determining if the person is in violation of this section.

(4) If a person did not sell or rent or offer to sell or rent a good or service listed in subsection (1) of this section prior to the Governor's implementation of this section, the price at which a good or service was generally available in the area for which the declaration was issued shall be used in determining if the person is in violation of this section.

(5) Nothing in this section shall be affected by the requirements of KRS 39A.090.

➔Section 8. KRS 45A.690 is amended to read as follows:

(1) As used in KRS 45A.690 to 45A.725:

(a) "Committee" means the Government Contract Review Committee of the Legislative Research Commission;

(b) "Contracting body" means each state board, bureau, commission, department, division, authority, university, college, officer, or other entity, except the Legislature, authorized by law to contract for personal services. "Contracting body" includes the Tourism Development Finance Authority with regard to tax incentive agreements;

(c) "Governmental emergency" means an unforeseen event or set of circumstances that creates an emergency condition as determined by the committee by promulgation of an administrative regulation;

(d) "Memorandum of agreement" means any memorandum of agreement, memorandum of understanding, program administration contract, interlocal agreement to which the Commonwealth is a party,

privatization contract, or similar device relating to services between a state agency and any other governmental body or political subdivision of the Commonwealth or entity qualified as nonprofit under 26 U.S.C. sec. 501(c)(3) not authorized under KRS Chapter 65 that involves an exchange of resources or responsibilities to carry out a governmental function. It includes agreements by regional cooperative organizations formed by local boards of education or other public educational institutions for the purpose of providing professional educational services to the participating organizations and agreements with Kentucky Distinguished Educators pursuant to KRS 158.782. This definition does not apply to:

1. Agreements between the Transportation Cabinet and any political subdivision of the Commonwealth for road and road-related projects;
2. Agreements between the Auditor of Public Accounts and any other governmental agency or political subdivision of the Commonwealth for auditing services;
3. Agreements between state agencies as required by federal or state law;
4. Agreements between state agencies and state universities or colleges only when the subject of the agreement does not result in the use of an employee or employees of a state university or college by a state agency to fill a position or perform a duty that an employee or employees of state government could perform if hired, and agreements between state universities or colleges and employers of students in the Commonwealth work-study program sponsored by the Kentucky Higher Education Assistance Authority;
5. Agreements involving child support collections and enforcement;
6. Agreements with public utilities, providers of direct Medicaid health care to individuals except for any health maintenance organization or other entity primarily responsible for administration of any program or system of Medicaid managed health care services established by law or by agreement with the Cabinet for Health and Family Services, and transit authorities;
7. Nonfinancial agreements;
8. Any obligation or payment for reimbursement of the cost of corrective action made pursuant to KRS 224.60-140;
9. Exchanges of confidential personal information between agencies;
10. Agreements between state agencies and rural concentrated employment programs; or
11. Any other agreement that the committee deems inappropriate for consideration;

(e) "Motion picture or entertainment production" means the same as defined in KRS 154.61-010;

(f) "Multicontract" means a group of personal service contracts between a contracting body and individual vendors providing the same or substantially similar services to the contracting body that, for purposes of the committee, are treated as one (1) contract;

(g) "Nurse aide" means an individual who has successfully completed the nurse aide training and competency evaluation program and may include a nursing student, medication aide, or a person employed through a ***health care services agency as defined in Section 1 of this Act***~~[nursing pool]~~ who provides nursing or nursing-related services to a resident in a nursing facility, excluding:

1. An individual who is a licensed health professional;
2. A volunteer who provides the nursing or nursing-related services without monetary compensation; or
3. 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;

(h) "Personal service contract" means an agreement whereby an individual, firm, partnership, or corporation is to perform certain services requiring professional skill or professional judgment for a specified period of time at a price agreed upon. It includes all price contracts for personal services between a governmental body or political subdivision of the Commonwealth and any other entity in any amount. This definition does not apply to:

1. Agreements between the Department of Parks and a performing artist or artists for less than five thousand dollars ($5,000) per fiscal year per artist or artists;

2. Agreements with public utilities, foster care parents, providers of direct Medicaid health care to individuals except for any health maintenance organization or other entity primarily responsible for administration of any program or system of Medicaid managed health care services established by law or by agreement with the Cabinet for Health and Family Services, individuals performing homemaker services, and transit authorities;

3. Agreements between state universities or colleges and employers of students in the Commonwealth work study program sponsored by the Kentucky Higher Education Assistance Authority;

4. Agreements between a state agency and rural concentrated employment programs;

5. Agreements between the State Fair Board and judges, officials, and entertainers contracted for events promoted by the State Fair Board;

6. Agreements between the Department of Public Advocacy and attorneys for the representation of indigent clients who are entitled to representation under KRS Chapter 31 and who, by reason of conflict or otherwise, cannot be represented by the department, subject to quarterly reports of all such agreements to the committee;

7. Agreements between the Office of Kentucky Veterans' Centers and licensed nurses and nurse aides in order to provide critically needed long-term care to Kentucky veterans who are residents in state veterans' nursing homes pursuant to KRS 40.325; or

8. Any other contract that the committee deems inappropriate for consideration;

(i) "Tax incentive agreement" means an agreement executed under KRS 154.61-030; and

(j) "Tourism Development Finance Authority" means the authority established by KRS 148.850.

(2) Compliance with the provisions of KRS 45A.690 to 45A.725 does not dispense with the requirements of any other law necessary to make the personal service contract or memorandum of agreement valid.

➔Section 9. KRS 216.785 is amended to read as follows:

As used in KRS 216.785 to 216.793, unless the context otherwise requires:

(1) "Assisted-living community" shall have the same meaning as in KRS 194A.700.

(2) "Crime" means a conviction of or a plea of guilty to a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or the commission of a sex crime. Conviction of or a plea of guilty to an offense committed outside the Commonwealth of Kentucky is a crime if the offense would have been a felony in Kentucky if committed in Kentucky.

(3) ***"Direct care service" has the same meaning as in Section 1 of this Act***~~["Direct service" means personal or group interaction between the employee and the nursing facility resident or the senior citizen]~~.

(4) ***"Health care services agency" has the same meaning as in Section 1 of this Act***~~["Nursing pool" means any person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment in nursing facilities for medical personnel including, but not limited to, nurses, nursing assistants, nurses' aides, and orderlies]~~.

(5) "Senior citizen" means a person sixty (60) years of age or older.

➔Section 10. KRS 216.787 is amended to read as follows:

(1) No agency providing services to senior citizens which are funded by the Department for Community Based Services of the Cabinet for Health and Family Services or the Department for Aging and Independent Living of the Cabinet for Health and Family Services shall employ persons in a position which involves providing direct ***care*** services to a senior citizen if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or the commission of a sex crime.

(2) Operators of service provider agencies may employ persons convicted of or pleading guilty to an offense classified as a misdemeanor.

(3) Each service provider agency providing direct *care* services to senior citizens as specified under KRS 216.785 to 216.793 shall request all conviction information from the Justice and Public Safety Cabinet for any applicant for employment prior to employing the applicant.

➔Section 11. KRS 216.789 is amended to read as follows:

(1) No long-term care facility as defined by KRS 216.535(1), ***health care services agency***~~[nursing pool]~~ providing staff to a nursing facility, or assisted-living community shall knowingly employ a person in a position which involves providing direct *care* services to a resident or client if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime.

(2) A nursing facility, ***health care services agency***~~[nursing pool]~~ providing staff to a nursing facility, or assisted-living community may employ persons convicted of or pleading guilty to an offense classified as a misdemeanor if the crime is not related to abuse, neglect, or exploitation of an adult.

(3) Each long-term care facility as defined by KRS 216.535(1), ***health care services agency***~~[nursing pool]~~ providing staff to a nursing facility, or assisted-living community shall request all conviction information from the Justice and Public Safety Cabinet for any applicant for employment pursuant to KRS 216.793.

(4) The long-term care facility, ***health care services agency***~~[nursing pool]~~ providing staff to a nursing facility, or assisted-living community may temporarily employ an applicant pending the receipt of the conviction information.

➔Section 12. KRS 216.793 is amended to read as follows:

(1) Each application form provided by the employer, or each application form provided by a facility either contracted or operated by the Department for Behavioral Health, Developmental and Intellectual Disabilities of the Cabinet for Health and Family Services, to the applicant for initial employment in an assisted-living community, nursing facility, or ***health care services agency***~~[nursing pool]~~ providing staff to a nursing facility, or in a position funded by the Department for Community Based Services of the Cabinet for Health and Family Services or the Department for Aging and Independent Living of the Cabinet for Health and Family Services and which involves providing direct *care* services to senior citizens shall conspicuously state the following: "FOR THIS TYPE OF EMPLOYMENT STATE LAW REQUIRES A CRIMINAL RECORD CHECK AS A CONDITION OF EMPLOYMENT."

(2) Any request for criminal records of an applicant as provided under subsection (1) of this section shall be on a form or through a process approved by the Justice and Public Safety Cabinet or the Administrative Office of the Courts. The Justice and Public Safety Cabinet or the Administrative Office of the Courts may charge a fee to be paid by the applicant or state agency in an amount no greater than the actual cost of processing the request.

➔Section 13. 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 operating as ***health care services agencies as defined in Section 1 of this Act***~~[nursing pools]~~; group homes; licensed residential crisis stabilization units; 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; the relocation of acute care beds which occur

among acute care hospitals under common ownership and which are located in the same area development district so long as there is no substantial change in services and the relocation does not result in the establishment of a new service at the receiving hospital for which a certificate of need is required; the redistribution of beds by licensure classification within an acute care hospital so long as the redistribution does not increase the total licensed bed capacity 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) Outpatient health facilities or health services that:

1. Do not provide services or hold patients in the facility after midnight; and

2. Are exempt from certificate of need and licensure under subsection (3) of this section;

(d) 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;

(e) 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;

(f) 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

(g) 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.

(3) The following outpatient categories of care shall be exempt from certificate of need and licensure on July 14, 2018:

(a) Primary care centers;

(b) Special health clinics, unless the clinic provides pain management services and is located off the campus of the hospital that has majority ownership interest;

(c) Specialized medical technology services, unless providing a State Health Plan service;

(d) Retail-based health clinics and ambulatory care clinics that provide nonemergency, noninvasive treatment of patients;

(e) Ambulatory care clinics treating minor illnesses and injuries;

(f) Mobile health services, unless providing a service in the State Health Plan;

(g) Rehabilitation agencies;

(h) Rural health clinics; and

(i) Off-campus, hospital-acquired physician practices.

(4) The exemptions established by subsections (2) and (3) of this section shall not apply to the following categories of care:

(a) An ambulatory surgical center as defined by KRS 216B.015(4);

(b) A health facility or health service that provides one (1) of the following types of services:

1. Cardiac catheterization;

2. Megavoltage radiation therapy;

3. Adult day health care;

4. Behavioral health services;

5. Chronic renal dialysis;

6. Birthing services; or

7. Emergency services above the level of treatment for minor illnesses or injuries;

(c) A pain management facility as defined by KRS 218A.175(1);

(d) An abortion facility that requires licensure pursuant to KRS 216B.0431; or

(e) A health facility or health service that requests an expenditure that exceeds the major medical expenditure minimum.

(5) An existing facility licensed as an 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 an intermediate care or nursing home to the nursing facility licensure category.

(6) 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.

(7) 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 (5) 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.

Signed by Governor April 8, 2022.

CABINET FOR HEALTH AND FAMILY SERVICES

Office of Inspector General

Division of Health Care

(New Administrative Regulation)

906 KAR 1:210. Health care services agencies.

RELATES TO: KRS 216.718 – 216.728, 216.785 – 216.793

STATUTORY AUTHORITY: KRS 216.720(2), 216.728(2)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216.720(2) requires the cabinet to promulgate administrative regulations in accordance with KRS Chapter 13A to establish the application process for registration of health care services agencies. KRS 216.728(2) requires the cabinet to promulgate administrative regulations in accordance with KRS Chapter 13A to establish requirements for health care services agencies to submit quarterly reports. This administrative regulation establishes requirements for health care services agency registration and quarterly reporting.

Section 1. Definitions. (1) "Assisted-living community" is defined by KRS 216.718(1).

(2) "Cabinet" is defined by KRS 216.718(2).

(3) "Controlling person" is defined by KRS 216.718(3).

(4) "Direct care service" is defined by KRS 216.718(4).

(5) "Direct care staff" is defined by KRS 216.718(5).

(6) "Health care services agency" is defined by KRS 216.718(6).

(7) "Hospital" is defined by KRS 216.718(7).

(8) "Long-term care facilities" is defined by KRS 216.718(8).

Section 2. Registration. A health care services agency that refers direct care staff to assisted-living communities, long-term care facilities, or hospitals in Kentucky shall register with the cabinet as required by KRS 216.720(1).

Section 3. Application and Fees. (1) An applicant for initial registration or annual renewal as a health care services agency shall submit to the Office of Inspector General:

(a) A completed Application for Registration to Operate a Health Care Services Agency; and

(b) In accordance with KRS 216.720(2)(f), an accompanying fee in the amount of $3,000, made payable to the Kentucky State Treasurer.

(2) As a condition of annual renewal, the application required by subsection (1) of this section shall be submitted to the cabinet at least sixty (60) days prior to the date of expiration of the agency's registration.

(3) In accordance with KRS 216.720(1), each separate location of a health care services agency shall register and obtain a separate registration.

(4)(a) Name change. A health care services agency shall:

1. Notify the Office of Inspector General in writing within ten (10) calendar days of the effective date of a change in the agency's name; and

2. Submit a processing fee of twenty-five (25) dollars.

(b) Change of location. A health care services agency shall not change the location where a facility is operated until an Application for Registration to Operate a Health

Care Services Agency accompanied by a fee of one hundred (100) dollars is filed with the Office of Inspector General.

(c) Change of ownership.

1. In accordance with KRS 216.720(4), if a controlling person changes, the health care services agency is sold, or the management is transferred, the agency shall submit to the Office of Inspector General a completed Application for Registration to Operate a Health Care Services Agency accompanied by a fee of $3,000 no later than thirty (30) calendar days from the effective date of the change.

2. A change of ownership shall be deemed to occur if more than twenty-five (25) percent of an existing health care services agency or capital stock or voting rights of the corporation is purchased, leased, or otherwise acquired by one (1) person from another.

Section 4. Scope of Operations. (1) In accordance with KRS 216.722(1), a health care services agency shall:

(a) Retain documentation that each direct care staff contracted with or employed by the agency meets the minimum licensing, certification, training, and continuing education standards for his or her position;

(b) Comply with all pertinent requirements relating to the health and other qualifications of personnel employed in:

1. An assisted-living community;

2. A long-term care facility; or

3. A hospital;

(c) Carry all professional and general liability insurance coverage to insure against loss, damage, or expense incident to a claim arising out of the death or injury of any

person as the result of negligence or malpractice in the provision of direct care services by the health care services agency or any direct care staff;

(d) Carry an employee dishonesty bond in the amount of $10,000;

(e) Maintain coverage for workers' compensation for all direct care staff; and

(f) Retain all records for five (5) calendar years and make all records immediately available to the cabinet upon request.

(2) A health care services agency shall demonstrate compliance with:

(a) KRS 216.724;

(b) KRS 216.789; and

(c) KRS 216.793.

Section 5. Quarterly Reports. (1) In accordance with KRS 216.728, a health care services agency shall submit quarterly reports to the cabinet that include the following information:

(a) The name, professional licensure or certification, and assigned location for each direct care staff;

(b) The length of time the direct care staff person has been assigned to the assisted-living community, long-term care facility, or hospital and the total hours worked; and

(c) For all long-term care facilities or hospitals that participate in the Medicare and Medicaid programs:

1. Copies of all invoices submitted to the long-term care facility or hospital; and

2. Proof of payment by the long-term care facility or hospital.

(2) The quarterly reports shall be submitted to the cabinet for the preceding

calendar quarter by February 1, May 1, August 1, and November 1 of each year.

Section 6. Complaints. In accordance with KRS 216.726, a complaint relating to a health care services agency or direct care staff may be made in accordance with the instructions provided in the complaint information document available for download from the Office of Inspector General's Web site: https://chfs.ky.gov/agencies/os/oig/dhc/Pages/default.aspx.

Section 7. Denial, Expiration, Revocation, and Fines. (1) The cabinet shall deny an Application for Registration to Operate a Health Care Services Agency if:

(a) The applicant or existing agency knowingly misrepresents or submits false information on the application;

(b) The applicant or existing agency fails to provide the information and fee required by Section 3(1) of this administrative regulation;

(c) The applicant or existing agency fails to comply with Section 4(1) of this administrative regulation; or

(d) A controlling person in the entity applying for registration was a controlling person in a previously registered health care services agency that had its registration revoked for noncompliance during the five (5) year period immediately preceding the filing of the application.

(2)(a) In accordance with KRS 216.720(4), a health care services agency's registration shall expire one (1) year from the date of issuance.

(b) If the health care services agency fails to renew its registration pursuant to Section 3(2) of this administrative regulation:

1. Its registration shall be cancelled effective one (1) day after the expiration date;

2. The Office of Inspector General shall document the agency's registration as inactive; and

3. The agency shall not continue to refer staff to an assisted-living community, long-term care facility, or hospital in Kentucky until its registration is renewed.

(3) Failure to comply with Section 4(1) of this administrative regulation shall result in:

(a) Revocation of registration; and

(b) A monetary penalty in the amount of $25,000.

(4) The cabinet shall revoke registration if:

(a) In accordance with KRS 216.722(3), the cabinet determines that a health care services agency knowingly provided to an assisted-living community, a long-term care facility, or a hospital direct care staff who have illegally or fraudulently obtained or been issued a diploma, registration, license, certification, or criminal background check; or

(b) The cabinet determines that there has been substantial failure by the health care services agency to comply with the provisions of this administrative regulation or KRS 216.718 – 216.728.

Section 8. Notice of Adverse Action. (1) Except for a violation of KRS 216.722(3), OIG shall provide written notice of adverse action at least thirty (30) calendar days prior to the effective date of the denial or revocation.

(2) In accordance with KRS 216.722(3), the cabinet shall immediately notify a health care services agency that its registration will be revoked in fifteen (15) days if the cabinet determines that the agency has knowingly provided to an assisted-living community, long-term care facility, or a hospital direct care staff who have illegally or

fraudulently obtained or been issued a:

(a) Diploma, registration, license, or certification; or

(b) Criminal background check.

(3) A notice of adverse action issued in accordance with subsection (1) or (2) of this section shall:

(a) Explain the reason for the denial or revocation, and monetary penalty if applicable;

(b) Advise the health care services agency of the right to request an appeal prior to the effective date of the denial or revocation, and monetary penalty if applicable; and

(c) Specify that the adverse action shall be stayed if an appeal is requested.

Section 9. Closure of a Health Care Services Agency. If a health care services agency closes voluntarily or as the result of denial or revocation of the registration, the agency shall relinquish to the cabinet its registration to operate as a health care services agency immediately after the effective date of the closure.

Section 10. Appeals. A health care services agency that submits a written request for appeal within thirty (30) calendar days of the date the agency receives a notice of adverse action, including revocation pursuant to KRS 216.722(3), shall be afforded a hearing in accordance with KRS Chapter 13B.

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

(a) Form OIG 1:210, "Application for Registration to Operate a Health Care Services Agency", August 2022 edition; and

(b) Form OIG 1:210-A, "Quarterly Report", August 2022 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Inspector General, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. This material may also be viewed on the Office of Inspector General's Web site at: https://chfs.ky.gov/agencies/os/oig/dhc/Pages/ltcapplications.aspx.

906 KAR 1:210

REVIEWED:

8/2/2022
Date

DocuSigned by:
Adam Mather
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Adam Mather, Inspector General
Office of Inspector General

APPROVED:

8/2/2022
Date

DocuSigned by:
Eric Friedlander
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Eric C. Friedlander, Secretary
Cabinet for Health and Family Services

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on October 24, 2022, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this hearing shall notify this agency in writing by October 17, 2022, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation until October 31, 2022. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. In the event of an emergency, the public hearing will be held using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor in advance of the scheduled hearing. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Specialist, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, KY 40621; Phone: 502-564-6746; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 906 KAR 1:210
Agency Contact: Kara Daniel; Stephanie Brammer-Barnes
Phone Number: (502) 564 – 2888
Email: karal.daniel@ky.gov; sbrammerbarnes@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-6746
Email: CHFSregs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes requirements for health care services agency registration.

(b) The necessity of this administrative regulation: This new administrative regulation is necessary to comply with KRS 216.718 – 216.728 (HB 282).

(c) How this administrative regulation conforms to the content of the authorizing statutes: This new administrative regulation conforms to the content of KRS 216.718 – 216.728 (HB 282) by establishing requirements for health care services agency registration.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This new administrative regulation assists in the effective administration of the statutes by establishing requirements for the registration of health care services agencies as required by HB 282 enacted by the 2022 General Assembly.

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

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This new administrative regulation affects entities seeking registration as a health care services agency. It is not known how many entities will apply for registration.

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

(a) List the actions that each of the regulated entities identified in question (3) will

have to take to comply with this administrative regulation or amendment: In accordance with HB 282 and this administrative regulation, entities seeking registration as a health care services agency will be required to submit an initial and annual renewal application to the cabinet. The requirements for registration and quarterly reporting are established in KRS 216.720 and 216.722, and Sections 3 through 5 of this administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): KRS 216.720(2)(f) establishes an initial and annual registration fee of $3,000. KRS 216.722(1) requires health care services agencies to carry professional and general liability insurance as well as an employee dishonesty bond in the amount of $10,000. This administrative regulation also establishes a processing fee of $25 for a change of name and a processing fee of $100 for a change of location.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Entities seeking registration as a health care services agency must demonstrate compliance with this administrative regulation and KRS 216.718 – 216.728.

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

(a) Initially: The Office of Inspector General (OIG) is seeking to hire one (1) additional grade 15 position to implement and oversee HB 282's new registration program for health care services agencies. The cost of the additional staff person will be approximately $88,000.

(b) On a continuing basis: The continuing costs will be approximately $88,000 per year.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: State general funds and agency monies will be used to implement and enforce this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: KRS 216.720(2)(f) establishes an initial and annual registration fee of $3,000. In addition, this administrative regulation establishes a processing fee of $25 for a change of name and a processing fee of $100 for a change of location.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation establishes an initial and annual registration fee of $3,000 in accordance with KRS 216.720(2)(f). In addition, this administrative regulation establishes a processing fee of $25 for a change of name and a processing fee of $100 for a change of location.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applicable as compliance with this administrative regulation applies equally to all entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 906 KAR 1:210
Agency Contact: Kara Daniel; Stephanie Brammer-Barnes
Phone Number: (502) 564 – 2888
Email: karal.daniel@ky.gov; sbrammerbarnes@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-6746
Email: CHFSregs@ky.gov

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation impacts health care services agencies and the Cabinet for Health and Family Services, Office of Inspector General.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 216.720(2), 216.728(2)

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

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? KRS 216.720(2)(f) establishes an initial and annual registration fee of $3,000. KRS 216.722(2) authorizes the cabinet to impose a fine of $25,000 for noncompliance. In addition, this administrative regulation establishes a processing fee of $25 for a change of name and a processing fee of $100 for a change of location. It is not known how many entities will apply for registration. Therefore, the cabinet is not able at this time to predict how much additional revenue will be generated.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? KRS 216.720(2)(f) establishes an initial and annual registration fee of $3,000. KRS 216.722(2) authorizes the cabinet to impose a fine of $25,000 for noncompliance. In addition, this administrative regulation establishes a processing fee of $25 for a change of name and a processing fee of $100 for a change of location. It is not known how many entities will apply for registration. Therefore, the cabinet is not able at this time to predict how much additional revenue will be generated.

(c) How much will it cost to administer this program for the first year? The Office of Inspector General (OIG) is seeking to hire one (1) additional grade 15 position to implement and oversee HB 282's new registration program for health care services agencies. The cost of the additional staff person will be approximately $88,000.

(d) How much will it cost to administer this program for subsequent years? The continuing costs will be approximately $88,000 per year.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-):
Expenditures (+/-):
Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year? This administrative regulation will not generate cost savings for regulated entities during the first year.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years? This administrative regulation will not generate cost savings for regulated entities during subsequent years.

(c) How much will it cost the regulated entities for the first year? In accordance with KRS 216.722(2), this administrative regulation will cost regulated entities a fee of $3,000 during the first year. In accordance with KRS 216.722(1), regulated entities must carry all professional and general liability insurance and carry an employee dishonesty bond of $10,000.

(d) How much will it cost the regulated entities for subsequent years? In accordance with KRS 216.722(2), this administrative regulation will cost regulated entities a fee of $3,000 during subsequent years. In accordance with KRS 216.722(1), regulated entities must carry all professional and general liability insurance and carry an employee dishonesty bond of $10,000.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Cost Savings(+/-):
Expenditures (+/-):
Other Explanation:

(5) Explain whether this administrative regulation will have a major economic impact, as defined below. *"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)]*

It is not known how many entities will apply for registration. Therefore, the cabinet is not able to determine whether this administrative regulation will have a major economic impact on the regulated entities.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

906 KAR 1:210. Health care services agencies.

SUMMARY OF MATERIAL INCORPORATED BY REFERENCE

The Form OIG 1:210, "Application for Registration to Operate a Health Care Services Agency", August 2022 edition is the 6-page application form that entities are required to submit to the Office of Inspector General prior to obtaining registration to operate a health care services agency and annually thereafter as part of the renewal process.

The Form OIG 1:210-A, "Quarterly Report", August 2022 edition is the 1-page form that health care services agencies are required to use to meet the reporting requirements of KRS 216.728(2) and Section 5 of this administrative regulation.

A total of seven (7) pages are incorporated by reference.