



Implementation Status Of Four Laws Related To Health And Welfare

Research Report No. 436

Program Review And Investigations Committee

Kentucky Legislative Research Commission

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Implementation Status Of Four Laws Related To Health And Welfare

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Abstract

HB 501 (enacted in 2003) directs the chair of the HB 144 Commission to appoint an ad hoc committee to develop recommendations for the implementation of a self-determination model of funding services and supports for participants in the Supports for Community Living Program. The commission accepted the subcommittee's recommendations but deferred action pending legislative action on a proposed alternative to the recommended pilot program. The alternative was enacted as HB 116 in 2004. Two of the three main provisions of HB 322 (2004) have been implemented. Membership of an interagency council was revised in compliance with the bill. Kentucky postsecondary institutions reported that they have provided housing accommodation for disabled students as required by the bill. A joint ad hoc committee on transition services was not created as mandated by the bill. HB 671 (2004) requires the Cabinet for Health and Family Services to conduct an internal review of any case in which child abuse or neglect resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family and to report on the case reviews annually. It is unclear whether all required internal reviews have been done. The Governor created an external review panel in 2012 to review child fatalities and near fatalities determined to be due to child abuse or neglect. The cabinet has produced annual reviews as directed, but not every report met the September 1 reporting deadline. The legend drug repository program mandated in SB 23 (2005) has not been implemented. The bill also authorizes a pharmaceutical assistance program, contingent on approval from the US Centers for Medicare and Medicaid Services, with benefits limited to the amount of appropriations. A prescription assistance program has been created, but it is not the same program authorized by the bill.

Foreword

Program Review and Investigations Committee staff thank officials with the Cabinet for Health and Family Services for their help, particularly Murray Wood and Beth Jurek, who helped coordinate information gathering. Within the Legislative Research Commission, staff of the Administrative Regulation Review Subcommittee, Interim Joint Committee on Appropriations and Revenue, Interim Joint Committee on Health and Welfare, LRC Library, and Office of Budget Review provided valuable assistance.

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Contents

Summary	v
Implementation Status Of Four Laws Related To Health And Welfare.....	1
House Bill 501 (2003).....	1
Subcommittee On Self-Determination.....	1
Kentucky Independence Plus.....	3
House Bill 322 (2004).....	4
Membership Of The State Interagency Council For Services To Children With An Emotional Disability	4
Committee On Transition From Children’s To Adult Services.....	5
Housing Accommodation For Disabled Students.....	7
House Bill 671 (2004).....	8
Review Process.....	8
Annual Report.....	9
Senate Bill 23 (2005)	11
Legend Drug Repository Program.....	11
Kentucky Pharmaceutical Assistance Program	13
Endnotes.....	18

Table

1	Disabled Students Receiving First-Floor Priority Housing At Kentucky Public Postsecondary Schools, School Years 2008 To 2012.....	7
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Summary

At its February 2012 meeting, the Program Review and Investigations Committee directed that staff review the implementation status of four laws related to health and welfare.

House Bill 501 (Enacted In 2003)

HB 501 directs the chair of the Commission on Services and Supports for Individuals with Intellectual Disabilities and Other Developmental Disabilities (HB 144 Commission) to appoint an ad hoc committee to develop recommendations for the implementation of a self-determination model of funding services and supports for participants in the Supports for Community Living program. The program serves as an alternative to institutional care for individuals with developmental or intellectual disabilities.

A subcommittee was appointed and reported recommendations for a pilot program. The HB 144 Commission accepted the subcommittee's recommendations but deferred action pending legislative action on a proposed alternative to the pilot program. The alternative was enacted via HB 116 in 2004. The program operates similarly to the pilot program recommended by the subcommittee created under HB 501. However, HB 116 targets services for the aged or physically disabled, not the developmentally or intellectually disabled as under HB 501.

Eligible participants under HB 116 may choose the consumer-directed option for services, which gives participants more control over the services they receive and who provides them. The Cabinet for Health and Family Services has updated several other waiver programs to include a consumer-directed option. One of the programs is the Supports for Community Living waiver, which is the target for HB 501.

House Bill 322 (2004)

Section 1 of HB 322 directs that one member be added to and one agency membership changed for the then eight-member State Interagency Council for Services to Children with an Emotional Disability. The council consists of state agency representatives and the parent of a child with an emotional disability. In compliance with the bill, the director of the Division of Family Resource and Youth Services Centers was added. The Administrative Office of the Courts' representation on the council was changed from its executive director to the director general manager of its Office of Juvenile Services.

Section 2 directs two commissions to establish a joint ad hoc committee to make recommendations for implementing specific action plans to meet the needs of individuals 21 years of age transitioning from children's services systems to adult services systems and to make a final report by December 30, 2004. The two commissions are the Commission on Services and Support for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (HB 843 Commission) and the HB 144 Commission.

No ad hoc committee was established. According to the Cabinet for Health and Family Services, to which the two commissions are attached, each commission discussed youth transition issues during meetings in 2005. An Interagency Transition Council for Persons with Disabilities, with representatives from 15 state agencies, had been in existence since 1989. This council created an Interagency Transition Core Team. According to the cabinet, the two commissions did not form an ad hoc committee because the existing core team already served the same function.

Section 3 of the bill requires that state postsecondary institutions provide priority first-floor housing for those students informing the school of a disability. If an institution does not have such accommodation available, the student will be allowed to seek alternative on- or off-campus housing. Program Review staff contacted Kentucky public postsecondary residential education institutions. All responded that the law had been implemented, and most provided numbers of students who had been given the first-floor housing priority for recent school years.

House Bill 671 (2004)

HB 671, enacted in 2004, requires the Cabinet for Health and Family Services to conduct

- an internal review of any case in which child abuse or neglect resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family and
- report on the case reviews annually.

Based on an analysis of 41 child fatalities in 2009 and 2010, the *Lexington Herald-Leader* asserted that at least six additional cases from those years should have had internal reviews. In July 2012, the Governor created the Child Fatality and Near Fatality External Review Panel. The panel is to conduct “comprehensive reviews of child fatalities and near fatalities determined to be due to child abuse or neglect.”

All annual reports since 2004 are available on the cabinet’s website. The format and information reported have varied somewhat by year. In the few years prior to the 2011 version, the typical report included summary statistics of child fatality and near fatality cases for the reporting year, summary statistics for fatality and near fatality cases for a previous multiyear period, and descriptions of actions taken by the cabinet related to child abuse prevention. Beginning with the 2011 report, statistics on risk factors are also provided for all protective services cases and for cases in which abuse was substantiated, which is an improvement. The Program Review report suggests that different statistical techniques be used to analyze the data and that the descriptions of actions taken by the cabinet be better explained.

Senate Bill 23 (2005)

SB 23 has two primary components: a legend (prescription) drug repository program and the Kentucky Pharmaceutical Assistance Program, which may be established contingent on approval from the US Centers for Medicare and Medicaid Services. Both programs were to be in what is now the Cabinet for Health and Family Services. The legend drug repository program mandated by the bill has not been implemented. The Kentucky Prescription Assistance Program within the Cabinet for Health and Family Services is similar in name to the Kentucky Pharmaceutical Assistance Program authorized in SB 23, but it was created separately. There is some overlap in services between the two programs.

Implementation Status Of Four Laws Related To Health And Welfare

At its February 2012 meeting, the Program Review and Investigations Committee directed that staff assess the implementation of four laws related to health and welfare: HB 501 (2003), HB 322 (2004), HB 671 (2004), and SB 23 (2005).

At its February 2012 meeting, the Program Review and Investigations Committee directed that staff assess the implementation of four laws related to health and welfare. Some provisions of the laws have been implemented as directed; others have not. The laws, which were enacted in 2003, 2004, and 2005, are reviewed below.

House Bill 501 (2003)

HB 501, enacted in 2003, directs the HB 144 Commission to appoint an ad hoc committee to “develop recommendations for the implementation of a self-determination model of funding services and supports ... for persons who are receiving services or supports under the Supports for Community Living Program.”

HB 501, enacted in 2003, amends KRS 210.577 to direct the chair of the Commission on Services and Supports for Individuals with Intellectual Disabilities and Other Developmental Disabilities (HB 144 Commission) to appoint an ad hoc committee to develop recommendations for the implementation of a self-determination model of funding services and supports ... for persons who are receiving services or supports under the Supports for Community Living Program.

The Supports for Community Living Waiver program, within Kentucky’s Medicaid system, serves as an alternative to institutional care for individuals with developmental or intellectual disabilities by providing them with the supports and services they need to continue living in the community.

A subcommittee was appointed and reported recommendations for a pilot program. The HB 144 Commission accepted the subcommittee’s recommendations but deferred action pending a proposed alternative to the pilot program. The alternative, HB 116, was enacted in 2004.

Subcommittee On Self-Determination

The chair of the HB 144 Commission created the Subcommittee on Self-Determination in June 2003. The subcommittee first met on July 16 and, according to its report, met nearly biweekly.¹ The subcommittee’s December 2003 report includes recommendations for implementing a self-determination model.

The subcommittee was appointed. It recommended that a pilot program be initiated to serve 200 to 250 people who were already receiving supports and services through the Supports for Community Living program.

The subcommittee recommended that a pilot program be initiated to serve 200 to 250 people who were already receiving supports and services through the Supports for Community Living program. The subcommittee outlined in general terms what it envisioned for the pilot program.

The subcommittee noted that the following beliefs should be the foundation of any self-determination pilot program:

- People with developmental or intellectual disabilities should have the freedom to live meaningful lives in the community.
- They should have authority over a targeted amount of public dollars needed for their support.
- Those supports and services should be organized in ways that are life-enhancing and meaningful for each participant.

Central to the proposed pilot program was the idea that various people would be involved in creating and helping to manage each participant's budget and care plan. A fiscal intermediary would also be needed to ensure responsible handling of public money.

Central to the proposed pilot program was the concept of a support broker. For each participant, support brokers would help develop an individualized budget, provide information about the supports and services available in the community, and help develop a plan for acquiring the needed services with the budgeted amount. A support coordinator would then help implement the plan by finding providers to deliver supports and services to the participant. This coordinator would also be in charge of monitoring the participant's satisfaction, health, safety, and welfare. To ensure responsible handling of public money, a fiscal intermediary would act as an agent or employer for participants hiring their own workers. This intermediary would accept invoices from and process payments to providers based on the participant's agreed-upon plan, and would also issue monthly reports of expenditures.

The subcommittee's report gave little guidance in terms of who was to fill these various roles or how the cabinet should proceed in rolling out the pilot program. The report does note that education for "existing and potential providers, for consumers and their circles of support, and for fiscal intermediaries and support brokers" would be of utmost importance if the pilot program was to succeed. The subcommittee concluded its report by recommending that either it "or a similar diverse group be convened to continue the development of the program as the Cabinet moves toward application for or amendment of a waiver to make self-determination a reality in this state."²

The HB 144 Commission accepted the subcommittee's recommendations but delayed action in favor of endorsing proposed legislation that was enacted as HB 116 in 2004.

Minutes from the HB 144 Commission's December 11, 2003, meeting indicate that the commission voted to accept the subcommittee's report and recommendations. Following the vote, Rep. Jimmie Lee, a member of the commission, presented draft

legislation as an alternative to the proposed pilot program. The commission voted to accept the subcommittee's recommendations but to delay action in favor of endorsing Rep. Lee's legislation, which was enacted as The Kentucky Independence Plus through Consumer-Directed Services Program Act of 2004 (HB 116).

Kentucky Independence Plus

Kentucky Independence Plus, created under HB 116, offers a consumer-directed option, which operates similarly to the pilot program, but targets the aged or physically disabled. HB 501 targets the developmentally or intellectually disabled.

The Kentucky Independence Plus through Consumer-Directed Services Program targets the aged or physically disabled. HB 501 targets the developmentally or intellectually disabled. Independence Plus operates similarly to the pilot program recommended by the subcommittee.

Under Kentucky Independence Plus, anyone eligible to participate in the Home and Community Based Waiver program may choose to use either the traditional option or the consumer-directed option. The traditional option involves receiving services from providers who are preapproved by the state; the consumer-directed option gives participants more control over which services they receive and who provides those services.

Similar to the pilot program recommended by the subcommittee, under the consumer-directed option, a participant assembles a team, which includes a fiscal intermediary, to help create and implement a plan of care.

Under the consumer-directed option, a participant assembles a team to help create and implement a plan of care. This team includes a representative (if applicable), support broker, assessment team, financial intermediary, employees, and anyone else the participant chooses. If an individual is unable to make decisions for herself or himself, a designated representative may be chosen. The support broker provides training, technical assistance, and support. The assessment team evaluates the participant's physical health, mental health, social supports, and living environment and identifies needs and services that the participant cannot manage or arrange. The fiscal intermediary is in charge of keeping track of the money in the participant's budget, processing payroll for workers, paying employees or vendors, and paying employer taxes.

The team works with the participant to create a person-centered plan of care. This plan includes the supports and services the individual needs to enhance independence and includes the amount, frequency, and duration of the expected services. A service must be included in the plan of care to be covered.

The Department for Medicaid Services sets the participant's consumer-directed option budget based on the services and supports identified and documented care needs. The fiscal

intermediary helps manage the budget, and the participant receives monthly printouts of how much has been spent and how much is left to spend.

The Cabinet for Health and Family Services (CHFS) has updated several other waiver programs to include a consumer-directed option. One of the programs is the Supports for Community Living waiver, which is the target for HB 501.

Since Kentucky Independence Plus was implemented, the Cabinet for Health and Family Services (CHFS) has updated several other waiver programs to include a consumer-directed option. One of the programs is within the Supports for Community Living waiver, which is the target for HB 501. As of February 2012, there were 5,130 individuals participating in consumer-directed option programs.

House Bill 322 (2004)

HB 322, enacted in 2004, includes three main provisions, two of which have been implemented.

House Bill 322, enacted in 2004, includes three main provisions, two of which have been implemented. The membership of an interagency council was revised in compliance with the bill. Kentucky postsecondary institutions reported that they have provided housing accommodation for disabled students as required by the bill. However, a joint ad hoc committee on transition services was not created as mandated by the bill.

Membership Of The State Interagency Council For Services To Children With An Emotional Disability

Section 1 of HB 322 directs that one member be added to and one agency membership be changed for the State Interagency Council for Services to Children with an Emotional Disability. CHFS reported that section 1 of HB 322 was implemented.

Section 1 of HB 322 directs that one member be added to and one agency membership be changed for the then eight-member State Interagency Council for Services to Children with an Emotional Disability. The council consists of state agency representatives and the parent of a child with an emotional disability. It oversees development of policy, planning, and budgeting for services to children with emotional disabilities.³

As codified in KRS 200.505(1)(a), the director of the Division of Family Resource and Youth Services Centers was added to the council, and the general manager of the Office of Juvenile Services replaced the executive director as the Administrative Office of the Courts' representative on the council. All members may use designees for representation on the council.

The council is attached to CHFS for administrative purposes. The cabinet reported that this section of HB 322 was implemented and that both of the new member positions had previously been represented at council meetings, but codification of their membership made them voting members.

Committee On Transition From Children's To Adult Services

Section 2 of HB 322 directs the HB 843 and HB 144 Commissions to establish a joint ad hoc committee to make recommendations of implementing action plans to meet the needs of individuals transitioning from children's services systems to adult services systems. The joint committee was to submit its final report by December 30, 2004.

Section 2 of HB 322 directs two commissions to establish a joint ad hoc committee to make recommendations for implementing specific action plans to meet the needs of individuals 21 years of age transitioning from children's services systems to adult services systems. The two commissions are the Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses (HB 843 Commission) and the Commission on Services and Supports for Individuals with Mental Retardation and Developmental Disabilities (HB 144 Commission). Both are attached to CHFS for administrative purposes. The bill requires the ad hoc committee to make a preliminary report by October 30, 2004, and a final report by December 30, 2004, to both commissions and to the Interim Joint Committee on Health and Welfare.

Codified in KRS 210.580, section 2 of HB 322 also describes the ad hoc committee's makeup, requiring that

[a]t least seventy-five percent (75%) of the membership shall be composed of family members of consumers of adult or child services, advocates, and nonprofit and community-based providers of adult and child services and supports.

Co-chairpersons of the two commissions would each designate the chairperson and appoint up to 10 members to the joint ad hoc committee. Members of both commissions could also serve in the ad hoc committee chairperson position or be appointed members.

According to the cabinet, section 2 of HB 322 was not implemented because the "existing multidisciplinary core team already existed and duplication was unnecessary." Program Review staff were unable to determine whether the Interagency Transition Core Team met the statutory requirements created by HB 322.

The cabinet reported that the ad hoc committee mandated by HB 322 was not created. According to cabinet officials, each commission had discussed youth transition issues during separate meetings in 2005. An Interagency Transition Council for Persons with Disabilities, composed of representatives from 15 state agencies, had been in existence since 1989. This council created a subcommittee called the Interagency Transition Core Team. According to the cabinet, the two commissions did not form an ad hoc committee because the "existing multidisciplinary core team already existed and duplication was unnecessary."⁴

Program Review staff were unable to determine from documentation provided by CHFS whether the multidisciplinary core team met the statutory requirements created by HB 322. In particular, it was not possible to verify that membership met the

required 75 percent threshold. It was reported that the core team consisted of “representatives from parent and consumer groups and from those state agencies that play a key role in the transition of youth from high school to post-secondary settings.”⁵

The cabinet indicated that the goal of the core team was to establish regional transition teams, which were to serve as forums for transition issues at a local level. Once the regional teams were established, the original core team disbanded.

The cabinet indicated that the Interagency Transition Core Team, whose ultimate goal was to initiate establishment of regional interagency transition teams, met frequently from 2003 to January 2005. The core team disbanded when the regional teams were established.⁶ The regional teams are made up of “representatives of agencies with central roles in the transition of youth from high school and of resources/supports specific to the particular region or community”⁷ The regional teams serve as a forum for transition issues and information sharing at a local level.

Examination of meeting notes indicates that the HB 843 commission began the actions needed to form the ad hoc committee, but cabinet officials explained that an undocumented, informal meeting after the June 2, 2005, meeting determined that the creation of the ad hoc committee would be duplicative and not cost effective.

Program Review staff examined the HB 843 and HB 144 Commissions’ meeting notes for references to the passage of HB 322 and the requirement to create an ad hoc committee. A HB 144 Commission Annual Status Report from September 30, 2004, mentions passage of the bill and its requirements.⁸ There is no further mention, either in succeeding HB 144 Commission meeting minutes or in reports, of the requirement to create an ad hoc committee.

Three HB 843 Commission meetings refer to the joint commission ad hoc committee. Minutes of the June 7, 2004, meeting indicate that the commission approved authorization to appoint members to the committee. Minutes of the December 9, 2004, meeting reference awaiting the status of the HB 144 Commission activity to continue forming the ad hoc committee. In the June 22, 2005, meeting minutes, a commissioner states that the ad hoc committee required by HB 322 should be formed.

There is no documentation indicating that the full commissions made the decision to not form the ad hoc committee. No documentation of this decision was forwarded to either commission or to the Interim Joint Committee on Health and Welfare.

CHFS officials explained that upon conclusion of the HB 843 Commission meeting on June 22, 2005, an informal meeting determined that creation of the ad hoc committee would be duplicative and not cost effective. There is no documentation of this informal meeting. There is no documentation indicating that the full commissions made the decision to not form the ad hoc committee. Since the committee was never formed, no reports were forwarded to the commissions or the legislative committee. No documentation was forwarded to the specified entities regarding the decision. It is unknown whether any entities have met the requirements of, or served as an equivalent to, those envisioned in the law.

Housing Accommodation For Disabled Students

Section 3 of HB 322 requires postsecondary institutions to prioritize first-floor housing for students with disabilities. If no accommodations are available, the student can seek alternative on- or off-campus housing.

Section 3 of HB 322 requires postsecondary institutions to implement measures related to housing accommodation for disabled students. As codified in KRS 164.9495, state postsecondary institutions must prioritize first-floor housing for students who inform the school of a disability. If no such accommodation is available, the student will be allowed to seek alternative on- or off-campus housing. The institution shall also maintain a record of on-campus housing assignments related to this requirement and notify appropriate safety and emergency personnel of the student’s housing location.

Program Review staff contacted Kentucky public postsecondary institutions and found that all had implemented this provision of HB 322.

Program Review staff contacted Kentucky public postsecondary residential education institutions. All eight institutions responded that the law had been implemented, and most provided numbers of students who had been given first-floor housing priority for school years 2008 to 2012. These numbers are presented in Table 1. Some of the institutions did not retain the numbers for all 5 years, and some did not have the numbers broken down by year.⁹

Table 1
Disabled Students Receiving First-Floor Priority Housing
At Kentucky Public Postsecondary Schools
School Years 2008 To 2012

Institution	2008	2009	2010	2011	2012
Eastern Kentucky University	—	—	3	7	10
Kentucky State University*					
Morehead State University**					
Murray State University	1	2	6	12	10
Northern Kentucky University	4	6	8	8	7
University of Kentucky	—	—	—	43	44
University of Louisville	0	0	0	0	0
Western Kentucky University	10	4	3	2	5

*Kentucky State University has received three requests for accommodation in housing in the past 5 years.

**Morehead State University does not track accommodation housing information for record keeping but noted that, if there has been a request, the university was able to provide the room or grant an off-campus waiver.

Source: Stephen Byars. Email to Jean Ann Myatt. May 18, 2012; Jane Vescio Fitzpatrick. Email to Jean Ann Myatt. July 24, 2012; Bob Jackson. Email to Jean Ann Myatt. May 22, 2012; Corlia Logsdon. Email to Jean Ann Myatt. July 6, 2012; Hope Danielle McLaughlin. Email to Jean Ann Myatt. May 18, 2012; Robbin Taylor. Email to Jean Ann Myatt. May 21, 2012; Virginia Underwood. Email to Jean Ann Myatt. June 27, 2012; Joseph Wind. Email to Jean Ann Myatt. May 17, 2012.

House Bill 671 (2004)

HB 671, enacted in 2004, requires CHFS to

- conduct an internal review of any case in which child abuse or neglect resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family and
- report on the case reviews annually.

On July 16, 2012, Governor Steve Beshear issued an executive order creating the Child Fatality and Near Fatality External Review Panel.

House Bill 671, enacted in 2004, created a new section of KRS 620.050 to require CHFS to

- conduct an internal review of any case in which child abuse or neglect resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family and
- report on the case reviews annually.^a

KRS 600.020(37) defines *near fatality* as an injury that, as certified by a physician, places the child in serious or critical condition. 922 KAR 1:420 defines *prior involvement* as “any assessment or investigation, of which the cabinet has record, with a child or family in the area of protection and permanency prior to the child’s fatality or near fatality investigation.”

On July 16, 2012, Governor Steve Beshear issued Executive Order 2012-0585 creating the Child Fatality and Near Fatality External Review Panel. The panel is to conduct “comprehensive reviews of child fatalities and near fatalities determined to be due to child abuse or neglect.” The 17-member panel will review relevant information, recommend improvements, and publish an annual report.

Given the focus and capacity of the panel to comprehensively review fatality and near fatality cases, this Program Review report provides an overview of the review process but concentrates on the annual reporting on cases. Based on an analysis of 41 child fatalities in 2009 and 2010, the *Lexington Herald-Leader* asserted that at least six additional cases from those years should have had internal reviews.¹⁰

Review Process

Once the cabinet has substantiated a child fatality or near fatality case, the Department for Community Based Services (DCBS) has 60 calendar days to schedule an internal review meeting. The purpose is to document previous involvement, discuss the current investigation, review existing practices, and identify areas for improvement.

The Department for Community Based Services’ (DCBS) Standards of Practice Online Manual details the procedures used for internal reviews of child fatality or near fatality cases.¹¹ Once the cabinet has substantiated a child fatality or near fatality case, the DCBS service region administrator has 60 calendar days to contact the central office child fatality liaison to schedule an internal review meeting. The purpose of this meeting is to document any previous involvement that the Division of Protection and Permanency had with the child or the child’s family, discuss the current investigation, review existing practices and identify areas for improvement, and discuss opportunities for staff training and development.

^a At the time of enactment, it was the Cabinet for Families and Children.

According to the DCBS manual, the following are required to participate in the internal review meeting:

- The service region administrator
- The service region administrator associate/service region clinical associate
- The family service office supervisor overseeing the investigation
- The social service worker investigating the case
- The central office child fatality or near fatality liaison
- Any social service worker or family service office supervisor previously involved in the case

The DCBS service region administrator also has discretion to invite the regional attorney, the child fatality or near fatality nurse administrator, or other relevant agency staff.

Proceedings of the internal review meeting must be submitted within 10 working days to the central office child fatality liaison, who distributes copies to the CHFS general counsel, the assistant director of the Division of Protection and Permanency, and director of the Division of Service Regions. The commissioner of DCBS is responsible for ensuring that the process is completed and that the action plan is carried out.

Proceedings of the internal review meeting are documented on a standardized template, which includes a section listing current practices the group identified as needing improvement and actions to be taken. Within 10 working days after the meeting and completion of the action plan, the DCBS service region administrator must submit the summary template to the central office child fatality liaison, who distributes copies to the CHFS general counsel, the assistant director of the Division of Protection and Permanency, and to the director of the Division of Service Regions. The commissioner of DCBS is responsible for ensuring that the process is completed according to the standard of practice and that recommendations in the action plan are used to enhance the delivery of services to support the department's efforts to keep Kentucky's children safe.

Annual Report

HB 671 also requires CHFS to submit an annual report containing "an analysis of all summaries of internal reviews occurring during the previous year and an analysis of historical trends." All annual reports since 2004 are available on the cabinet's website.

HB 671 also requires CHFS to submit a report to the governor, General Assembly, and state child fatality review team by September 1 of each year containing "an analysis of all summaries of internal reviews occurring during the previous year and an analysis of historical trends." All annual reports since 2004 are available on the cabinet's website.¹² Personnel at the Office of the Governor, the Legislative Research Commission, and Department for Public Health, to which the review team is attached, confirmed that their offices have received copies of the annual report since HB 671 was enacted. It is unknown how many of the reports were delivered by the September 1 deadline. The 2011 report came out in December 2011.

The format and information reported have varied by year. In the few years prior to the 2011 version, the typical report included summary statistics of child fatality and near fatality cases for the reporting year, summary statistics for fatality and near fatality cases for a previous multiyear period, and descriptions of actions taken by the cabinet related to child abuse prevention. The summary data presented in the reports include the sex, age, and race of the victims; the relationship of the perpetrators to the victims; the types of maltreatment involved in the cases; and risk factors such as the presence of substance abuse, domestic violence, or mental illness.

A weakness of the reports prior to 2011 is that important contextual information was omitted. Specifically, information was not usually provided on cases in which abuse was investigated or substantiated and in which there was no fatality or near fatality.

A weakness of the reports prior to 2011 is that important contextual information was omitted. Specifically, information was not usually provided on cases in which abuse was investigated or substantiated and in which there was no fatality or near fatality. In the 10-year period ending in 2009, for example, in 72 percent of the fatality and near fatality cases at least one of the child's caretakers was documented as a substance abuser. However, if substance abuse or other risk factors are to have value in identifying households at higher risk for fatality or near fatality, there must be a comparison for evaluating the risk factor.

Beginning with the 2011 report, statistics on risk factors were provided for all protective services cases and for cases in which abuse was substantiated. Having the comparative information should be helpful to members of the General Assembly and other readers of the report.

Beginning with the 2011 report, statistics on risk factors are also provided for all protective services cases and for cases in which abuse was substantiated. In 2011, in 74 percent of the fatality and near fatality cases over a 5-year period, at least one of the child's caretakers was documented as a substance abuser. However, substance abuse was documented in 62 percent of cases in which there was substantiated abuse but no fatality or near fatality over this period. This may indicate that substance abuse is a risk factor but is not an obvious warning of a potential fatality or near fatality. Having the comparative information should be helpful to members of the General Assembly and other readers of the report. Comparative information could also be useful for other factors—for example, demographics.

Determining the households in which there is abuse that has a higher risk of a fatality or near fatality is difficult, but it is critical that this be done as effectively as possible. In statistical terms, nearly all the analyses in the reports are univariate. This means that one potential variable is presented at a time, usually in a table. For example, Table 9 from the 2012 report shows that substance abuse was involved in 74 percent of fatality and near fatality cases. Domestic violence was involved in 62 percent of such cases. Both

conditions must be present in a significant percentage of cases, but this is not shown.

The cabinet should consider using multivariate statistical techniques to analyze abuse cases to predict which ones are at higher risk of resulting in child fatalities or near fatalities. The cabinet should also consider analyzing cases over a longer period of time.

The cabinet should consider using multivariate statistical techniques to analyze abuse cases to predict which ones are at higher risk of resulting in child fatalities or near fatalities. Multivariate analysis allows for the consideration of multiple factors at once to determine which ones are playing a more important role controlling for the effects of others. Multivariate analysis also allows the analyst to determine whether specific combinations of factors are most important in explaining outcomes. Having more cases to analyze would make the results of multivariate analyses more likely to be statistically significant, all else equal. In the 2012 report, cases are analyzed over the 5-year period ending in 2012. The cabinet should consider analyzing cases over a longer period of time.

In addition to needing more comprehensive analysis of child abuse cases, the cabinet should ensure that the list of newly implemented policies and procedures is directly tied to an analysis of the action plans created during the internal review process.

In addition to needing a more comprehensive analysis of child abuse cases, the cabinet should ensure that the list of newly implemented policies and procedures is directly tied to an analysis of the action plans created during the internal review process. There should be a discussion for each new policy or procedural change that allows the reader to understand why the action was taken, what the cabinet hopes to achieve with that action, and how the success or failure of the action will be measured.

Senate Bill 23 (2005)

The two primary components of **SB 23**, enacted in 2005, are a legend drug repository program and the Kentucky Pharmaceutical Assistance Program.

The two primary components of SB 23, enacted in 2005, are a legend drug repository program and the Kentucky Pharmaceutical Assistance Program, which may be established contingent on approval from the US Centers for Medicare and Medicaid Services with benefits provided by the program being limited to the amount of appropriations. Both programs were to be in what is now CHFS. The legend drug repository program mandated in the bill has not been implemented. A prescription assistance program has been created, but it is not the same program authorized by the bill.

Legend Drug Repository Program

The legend drug repository program encourages the donation of legend drugs or the supplies used to administer them for use by individuals who met certain eligibility criteria.

Legend drugs are prescription drugs, so named because federal law requires that their labels display a legend prohibiting sale without a prescription. SB 23 directs CHFS to create and maintain a legend drug repository program. The purpose is to encourage the donation of legend drugs or the supplies used to administer them for use by

individuals who meet certain eligibility criteria. Eligibility criteria were to be established through administrative regulations promulgated by the cabinet.

CHFS is responsible for promulgating administrative regulations related to aspects of implementing the bill such as requirements that a pharmacy or health facility must meet in order to participate, handling fees that a health facility may charge, and lists of legend drugs and supplies that may be accepted and that shall not be accepted.

The bill stipulates requirements that a legend drug or supplies used to administer a legend drug must meet in order to be accepted and dispensed. SB 23 also has provisions related to civil liability for health facilities, pharmacies, and health care providers.

CHFS did not establish and maintain a legend drug repository program as required by SB 23.

Cabinet officials confirmed that the legend drug repository program under SB 23 has not been implemented. They noted that although the program was intended for CHFS to implement, involvement from the Kentucky Board of Pharmacy was also needed.¹³

Cabinet officials noted several concerns regarding implementation of the law. First, mislabeled, or counterfeit, drugs were coming into circulation at the time the bill was signed into law. This made pharmacists cautious about implementing the program because of the potential for encountering these drugs. Pharmacists became apprehensive about what kind of drugs would be turned in and what pharmacies would have to do. The pharmacies also became concerned about getting into the business of what they referred to as “giving away drugs.”¹⁴

During the process of discussing implementation of the legend drug repository program, CHFS staff worked with the Board of Pharmacy, the Kentucky Pharmacists Association, and the Kentucky Association of Hospice and Palliative Care. No documentation of meeting discussions or the resulting decision not to implement the program was supplied by the cabinet. Cabinet officials were also unaware of any testimony or other official follow-up on implementation of the program before any committee of the General Assembly. The cabinet noted that no money was placed in the budget for implementation of the legend drug repository program. Although the cabinet stated that that was a consideration in not implementing the program, it never developed enough beyond the other concerns to the point that lack of funding

was a primary obstacle. Since the program was never implemented, no administrative regulations were promulgated.¹⁵

Other legislation has been filed related to the legend drug repository program since the enactment of SB 23 in 2005. HB 740 passed the House in the 2008 Regular Session with a committee substitute and went to the Senate Appropriations and Revenue Committee, where it remained. The bill would have amended KRS 194A.452, which was created by SB 23. The amendment was to require the cabinet to report on the operation of the program by October 1 of each year to the Interim Joint Committee on Health and Welfare. The House Committee Substitute to HB 740 added language stating that the cabinet may contract for services to establish and maintain a legend drug repository program, if funding is available.

Cabinet officials assert that other programs address the issue that the legend drug repository program is intended to address.

CHFS officials stated that “drug drop-offs” are now present at many locations across the state. They noted that there has been a tremendous response from citizens in making use of these drop-offs, which have a strong law enforcement presence. Cabinet officials asserted that this is an effective way of collecting drugs. They also stated that the Kentucky Prescription Assistance Program provides safe, low- or no-cost drugs directly from pharmacies to those in need. Cabinet officials stated that these combined efforts adequately attend to the problem that the legend drug repository program was intended to address.¹⁶

Kentucky Pharmaceutical Assistance Program

Under SB 23, the Kentucky Pharmaceutical Assistance Program was designed to coordinate prescription drug coverage with the prescription drug benefit under the Medicare Modernization Act. The program was contingent on approval from the US Centers for Medicare and Medicaid Services (CMS).

Under SB 23, the Kentucky Pharmaceutical Assistance Program may be established. If established, the program was to be administered by the Department for Medicaid Services (DMS). Creation of the program was contingent on approval from the US Centers for Medicare and Medicaid Services. The program would be required to coordinate prescription drug coverage with the prescription drug benefit under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (PL 108-173). SB 23 outlines eligibility requirements for drug benefits. For individuals meeting eligibility requirements, the program may pay all or some of the applicable costs required under the Medicare Part D pharmacy benefit program.

The bill includes steps that DMS must take in implementing the program. These include priority enrollment for particular groups, including Medicaid dual eligibles. A second enrollment priority group includes Medicare-eligible applicants who have an annual

household income up to 150 percent of the federal poverty guidelines and who meet the asset test as defined by the 2003 federal law.

DMS is granted flexibility in providing program benefits. For example, the department is allowed to enter into a contract with one or more prescription drug plans to coordinate prescription benefits of the program and the federal law. The department may also select, in compliance with relevant state law, a contractor to assist in the administration of the program. It may also negotiate administrative functions for the program with a preferred prescription drug plan. DMS is permitted to set the application and enrollment procedures and to determine which drugs would be covered by the plan.

SB 23 states that benefits provided through the Kentucky Pharmaceutical Assistance Program are to be limited to the amount of appropriations. The program is to be the payor of last resort and is to cover costs for participants who are not covered by the Medicare Part D program. With the exception of dual eligibles during the transition period, applicants who are qualified for prescription drug coverage under a public assistance program are deemed ineligible for the Kentucky Pharmaceutical Assistance Program for as long as they are so qualified under the public assistance program. Applicants are also deemed ineligible for the program if they are qualified for full coverage for pharmacy benefits under another plan of assistance or insurance, for as long as they are eligible to receive prescription drug coverage under the other plan. Applicants who are qualified for partial payments for pharmacy benefits under another insurance plan are eligible for the program, but they may receive reduced assistance from the program, due to partial coverage from the other plan.

Cabinet officials noted spoken advisement by CMS that state Medicare assistance programs would not be approved, as well as the lack of an appropriation, as reasons for not implementing the program as created in SB 23. The cabinet did implement the Kentucky Prescription Assistance Program, which was the result of 2008 RS HB 406, not the result of SB 23.

The Kentucky Prescription Assistance Program within CHFS is similar in name to the Kentucky Pharmaceutical Assistance Program authorized in SB 23, but it was created separately.

In response to the question of why the program from SB 23 was not created, cabinet officials noted that the bill's requirement to establish the program was contingent on approval from the Centers for Medicare and Medicaid Services. Cabinet staff stated that, at the time, they were orally advised by the centers that state Medicare assistance programs would not be approved. CHFS officials also noted that creation of the program was subject to appropriations. There were no appropriations for the program.¹⁷

HB 200 was introduced in the 2006 Regular Session to create the Kentucky Prescription Drug Patient Assistance Program. The bill passed the House and went to the Senate Health and Welfare Committee, where it remained. In the 2006-2008 enacted biennial budget for CHFS, \$125,000 was included in the General Fund within the Department for Public Health to establish the Kentucky Prescription Drug Patient Assistance Program in FY 2007. In FY 2008, \$200,000 was included within the general fund of the department for the same purpose.¹⁸

Enacted in 2008, HB 406, the executive branch budget bill, included an appropriation for the Kentucky Prescription Drug Patient Assistance Program, funded under Public Health. Included in the budget bill is \$400,000 for FY 2009 and \$600,000 in FY 2010 to continue the program. The purpose of these funds is to combine all programs in CHFS that assist individuals in obtaining free or reduced-price prescription drugs. The funds are also appropriated for the purpose of offering at least \$150,000 in grants each year of the biennium to local agencies and organizations providing these services in such a way that there exists the potential for statewide expansion. Implementation progress, including the amount of free drugs retained by each local agency or organization, was to be reported semiannually to the Interim Joint Committee on Appropriations and Revenue and the Interim Joint Committee on Health and Welfare. CHFS officials noted that the Kentucky Prescription Assistance Program, currently administered by the Department for Public Health, was created as a result of HB 406 in the 2008 Regular Session.¹⁹ Remaining discussion of the program relates to its current status as the Kentucky Prescription Assistance Program.

HB 301, also introduced in the 2008 Regular Session, would have established the Kentucky Senior Prescription Drug Assistance Program. The bill went to the House Health and Welfare Committee, where it remained.

According to CHFS officials, prescription assistance programs are controlled exclusively by pharmaceutical manufacturers or their foundations. Individuals must apply directly to the manufacturer program, and eligibility criteria are set by the respective manufacturer. For example, no pharmaceutical industry assistance program will accept a patient who is on Medicaid.²⁰ This is because these individuals already have pharmacy benefit coverage under Medicaid. CHFS officials noted that all state Medicaid programs have a prescription drug benefit. Federal rules for Medicaid limit the copayments that a state Medicaid program can

require. In Kentucky, individuals with Medicaid have minimal copayments for medications. Those copayments and exceptions are stipulated in administrative regulations. One exception is that children and pregnant women have no copayments. The state's Medicaid managed care organization framework also plays a role. Kentucky's contracts with three managed care organizations prohibit them from exceeding the copayments permitted in the Medicaid fee-for-service program.²¹

According to SB 23, the program, if established, must coordinate prescription drug coverage with the prescription drug benefit under the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Cabinet officials noted that the Kentucky Prescription Assistance Program has provided assistance to some beneficiaries of the prescription drug benefit under the federal law since approximately 2009. Previously, the pharmaceutical industry was hesitant to offer prescription assistance services to Medicare Part D recipients because of concerns that such action might be in violation of the federal anti-kickback law, delineated in the Social Security Act.²² In November 2005, the Office of Inspector General within the US Department of Health and Human Services issued a special advisory bulletin regarding patient assistance programs in relation to Medicare Part D enrollees. The bulletin stated that pharmaceutical manufacturer patient assistance programs subsidizing Part D cost-sharing amounts elicit significant concerns related to the anti-kickback law. It also noted that legal means are available for pharmaceutical manufacturers, and others, to help Part D beneficiaries access medically necessary drugs.²³ CHFS officials indicated that prescription assistance by pharmaceutical manufacturers to Part D recipients was not very common in Kentucky until 2008 to 2009. Some programs offer assistance to Medicare Part D recipients only on an individual basis.²⁴

CHFS officials indicated the complexity of prescription assistance programs. Some pharmaceutical companies have as many as seven programs open at any one time with varying eligibility requirements depending on the type of program and/or drug. For example, eligibility requirements, such as those related to poverty level, may vary. CHFS noted that the average federal poverty level requirement for most prescription assistance programs is set at 200 percent, but some allow up to 400 percent. Cabinet officials noted that prescription assistance programs can be overwhelming for the average consumer because of the large number of programs (200 to 400 on any given day). In programs in which a pharmaceutical manufacturer's foundation is involved, the

program may open or close at any time, depending on the donation goals of the foundation.²⁵

As it currently exists, the Kentucky Prescription Assistance Program allows for coordination and training of communities to assist citizens in understanding the intricate system of prescription assistance programs described above.²⁶ In accomplishing this, Department for Public Health staff work with medical personnel and community organizations to disseminate information about the program. Staff also work to identify community resources to assist individuals in accessing the prescription assistance programs. Clients whose financial resources make them ineligible for pharmaceutical manufacturers' existing prescription assistance programs receive consultation about other options for obtaining low-cost prescriptions.²⁷ The program uses a web-based software application, which improves efficiency in completing forms for patients. CHFS officials noted that each assistance form must still be hand signed by the patient and prescribing physician. It is then mailed or faxed to each separate company. Currently, the program has 250 or more community partner organizations actively participating. In 2011, the Department for Public Health began working with the Department for Behavioral Health, Developmental and Intellectual Disabilities on a pharmacy assistance program for behavioral health.²⁸

The Kentucky Prescription Assistance Program served nearly 36,000 patients in a 3-year period. This resulted in patients receiving free medications totaling nearly \$186 million.

CHFS officials noted that the Kentucky Prescription Assistance Program is funded at \$600,000 per year beginning in FY 2011. This is included in the Department for Public Health's base budget. The program is available statewide, and from July 2009 to July 2012, the Kentucky Prescription Assistance Program served 35,760 people. Patients received free medications with a total value of \$185,898,215 in that period. Also during that time, approximately 23,000 people seeking assistance through the program were determined to be ineligible for a pharmaceutical industry prescription assistance program. Ineligible patients were provided information on prescription discount cards and \$4 programs, for example, and/or referred to federally supported clinics, such as federally qualified health centers. The Kentucky Prescription Assistance Program has been entered in a number of award competitions: Harvard's Kennedy School of Government-Ash Center's Innovations in American Government Awards Program, the Council on State Governments' Innovation Awards, the National Association of County and City Health Officials' Model Practice Awards, and a competition by the Association of State and Territorial Health Officials.²⁹

It does not appear that reporting requirements contained in HB 406 have been fulfilled.

Regarding the requirement in HB 406 to report on progress in implementation of the program, cabinet officials noted that Department for Public Health officials were scheduled at least once to discuss the Kentucky Prescription Assistance Program before legislative committees during the first 2 years of the program's implementation, but presentations by department staff did not occur. Cabinet officials noted that the department's baseline biennial budget request for the Prevention and Quality Improvement Program included historical data on persons served and the value of prescription drugs obtained through the program.³⁰ To date, it appears that no report was ever filed with either of the interim joint committees noted in HB 406: Appropriations and Revenue, and Health and Welfare. Cabinet officials noted that the requirement is no longer in place because similar language was not included in subsequent budget bills. Therefore, the reporting requirement ended at the conclusion of the biennium covered by HB 406.³¹

Endnotes

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