

## STATEMENT OF EMERGENCY

907 KAR 1:022E, Nursing facility and intermediate care facility for an individual with mental retardation or a developmentally disability level of care criteria

(1) This emergency administrative regulation is being promulgated to revise the qualifying requirements regarding nursing facility (NF) level of care. An individual shall now be required to meet two (2) of nine (9) rather than three (3) of nine (9) NF level of care criteria and an individual shall not be discharged from an NF if he or she meets transfer trauma criteria. This action is being taken to enable the Department for Medicaid Services (DMS) to maximize the number of medically needy recipients to be served by the nursing facility and home and community based waiver service programs with the limited resources available to DMS.

(2) Failure to enact this administrative regulation on an emergency basis would pose an imminent threat to the safety and welfare of Medicaid recipients whose receipt of services may be otherwise jeopardized.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

---

Ernie Fletcher  
Governor

---

James. W. Holsinger, Jr., M.D., Secretary  
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Long Term Care and Disability Services

4 (Emergency Amendment)

5 907 KAR 1:022E. Nursing facility and intermediate care facility for an individual with mental  
6 retardation or a developmental disability [~~the mentally retarded and developmentally dis-~~  
7 ~~abled~~] level of care criteria.

8 RELATES TO: 42 C.F.R. 430, 431, 432, 433, 435, 440, 441, 442, 447, 455, 456, 42  
9 U.S.C. 1396a, b, c, d, g, i, l, n, o, p, r, r-2, r-3, r-5, s

10 STATUTORY AUTHORITY: KRS 194A.030(3), 194A.050(1), 205.520(3), 205.558

11 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health Services, De-  
12 partment for Medicaid Services, has responsibility to administer the Medicaid Program.

13 KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any  
14 requirement that may be imposed or opportunity presented by federal law for the provision  
15 of medical assistance to Kentucky's indigent citizenry. This administrative regulation estab-  
16 lishes the nursing facility (NF) and intermediate care facility for an individual with mental  
17 retardation or a developmental disability (ICF MR DD) level of care criteria as well as es-  
18 tablishes the provisions relating to NF and ICF MR DD services [~~nursing facility and inter-~~  
19 ~~mediate care facility the mentally retarded and developmentally disabled level of care crite-~~  
20 ~~ria~~] for which payment shall be made by the Medicaid Program on behalf of both the cate-  
21 gorically needy and medically needy recipients.

1 Section 1. Definitions. (1) "Department" means the Department for Medicaid Services  
2 or its designee.

3 (2) "Intermediate care facility for an individual with mental retardation or a developmental  
4 disability [~~the mentally retarded and developmentally disabled~~]" or "ICF-MR-DD" means a  
5 licensed intermediate care facility for an individual with mental retardation or a develop-  
6 mental disability [~~the mentally retarded and developmentally disabled~~] certified to the De-  
7 partment for Medicaid Services as meeting all standards for an intermediate care facility  
8 for an individual with mental retardation or a developmental disability [~~facilities for the men-~~  
9 ~~tally retarded and developmentally disabled~~].

10 (3) "Intermediate care for an individual with mental retardation or a developmental dis-  
11 ability [~~the mentally retarded and developmentally disabled~~] services" means care provided  
12 that is consistent with a combination of the services listed in Section 5 of this administra-  
13 tive regulation.

14 (4) "Intermittent skilled nursing care services" means services for an individual who re-  
15 quires skilled nursing care services at regular or irregular intervals, but not on a twenty-four  
16 (24) hour-per-day basis and not less than three (3) days per week.

17 (5) "Medical condition" means a usually-defective state of health relative to a clinical di-  
18 agnosis made by a licensed physician, physician assistant, or advanced registered nurse  
19 practitioner.

20 (6) "Nursing care services" means care provided that is consistent with a combination of  
21 the services listed in Section 4 of this administrative regulation and that is provided by or  
22 under the supervision of technical or professional staff in an institutional setting.

23 (7) "Nursing facility" or "NF" means:

24 (a) A facility:

- 1 1. To which the state survey agency has granted an NF license;
- 2 2. For which the state survey agency has recommended to the department certification
- 3 as a Medicaid provider; and
- 4 3. To which the department has granted certification for Medicaid participation; or
- 5 (b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and
- 6 1396l, if the swing bed is certified to the department as meeting requirements for the pro-
- 7 vision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), (d), 42 C.F.R.
- 8 447.280 and 482.66.

9 (8) "Nursing facility level of care" means that care that meets the criteria established in  
10 this administrative regulation for inpatient treatment of an individual in a nursing facility and  
11 that is based on a medical condition requiring professional or technical nursing care ser-  
12 vices to be ordered and supervised by a physician, physician assistant, or advanced regis-  
13 tered nurse practitioner on an ongoing basis.

14 (9) "Nursing facility with Medicaid waiver" or "NF-W" means a facility:

- 15 (a) To which the state survey agency has granted an NF license;
- 16 (b) For which the state survey agency has recommended to the department certification
- 17 as a Medicaid provider;
- 18 (c) To which the department has granted a waiver of the nursing staff requirement; and
- 19 (d) To which the department has granted certification for Medicaid participation.

20 (10) "Skilled nursing care services" means care that is consistent with a combination of  
21 the services listed in Section 4(2) of this administrative regulation and that is provided on a  
22 daily basis by, or under the supervision of, a registered nurse, licensed practical nurse, or  
23 certified therapist in an institutional setting.

24 (11) "Skilled rehabilitative services" means those therapy services which:

1 (a) Are expected to improve an individual's condition while the individual possesses  
2 reasonable potential for improvement in functional capability; and

3 (b) Do not include restorative and maintenance nursing procedures, including routine  
4 range of motion exercises and application of splints or braces by nurses and staff.

5 (12) "Stable medical condition" means a medical condition which is capable of being  
6 maintained in accordance with a planned treatment regimen requiring a minimum amount  
7 of medical supervision without significant change or fluctuation in a patient's condition or  
8 treatment regimen.

9 Section 2. Participation Requirements. A facility desiring to participate as a nursing fa-  
10 cility, nursing facility with waiver, or ICF-MR-DD shall meet the following requirements:

11 (1) An application for participation shall be made in accordance with 907 KAR 1:671  
12 and 907 KAR 1:672.

13 (2) A nursing facility shall have at least twenty (20) percent of all Medicaid certified beds,  
14 but not less than ten (10) beds, also certified to participate in Medicare unless the facility  
15 has obtained a Medicaid waiver of the nurse staffing requirement. If a nursing facility has  
16 less than ten (10) beds certified for Medicaid, all Medicaid certified beds shall also be cer-  
17 tified to participate in Medicare.

18 (3) If a nursing facility which has obtained a Medicaid waiver of the nurse staffing re-  
19 quirements chooses to participate in Medicare, the facility shall have at least twenty (20)  
20 percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to par-  
21 ticipate in Medicare. If less than ten (10) beds are certified for Medicaid, all Medicaid beds  
22 shall also be certified to participate in Medicare.

23 (4) A nursing facility or a nursing facility with waiver shall be required to comply with the  
24 preadmission screening and resident review requirements specified in 42 U.S.C. 1396r

1 and 907 KAR 1:755. A facility failing to comply with these requirements shall be subject to  
2 disenrollment, with exclusion from participation to be accomplished in accordance with 907  
3 KAR 1:671, 42 C.F.R. 431.153 and 431.154.

4 (5) A facility shall be required to be certified by the state survey agency as meeting NF,  
5 NF-W, or ICF-MR-DD status.

6 (6) In order to provide specialized rehabilitation services to an individual with a brain in-  
7 jury in accordance with Section 7 of this administrative regulation, a facility shall be accred-  
8 ited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

9 (7) A participating nursing facility shall be certified in accordance with standards and  
10 conditions specified in the Medicaid Nursing Facility Services Manual before the facility  
11 may operate a unit that provides:

12 (a) Preauthorized specialized rehabilitation services for a person with a brain injury; or

13 (b) Care for a person who is ventilator dependent.

14 Section 3. Payment Provisions. (1) Payment for nursing care services and ICF-MR-DD  
15 services shall be limited to those services meeting the care definitions established in Sec-  
16 tion 1 of this administrative regulation.

17 (2) An NF or NF-W shall receive payment for nursing care services provided to a Medi-  
18 caid-eligible individual meeting nursing facility level of care criteria if the services are pro-  
19 vided in a Medicaid-certified bed.

20 (3) An ICF-MR-DD shall receive payments for ICF-MR-DD services only.

21 Section 4. Determining Nursing Facility Level of Care. The department shall review and  
22 evaluate the health status and care needs of an individual in need of inpatient care giving  
23 consideration to the medical diagnosis, age-related dependencies, care needs, services  
24 and health personnel required to meet these needs and the feasibility of meeting the needs

1 through alternative institutional or noninstitutional services.

2 (1) An individual shall not qualify for Medicaid nursing facility level of care unless the in-  
3 dividual is qualified for admission, and continued stay as appropriate, under the preadmis-  
4 sion screening and resident review criteria specified in 42 U.S.C. 1396r and 907 KAR  
5 1:755.

6 (2) An individual shall qualify for skilled nursing care services if:

7 (a) On a daily basis:

8 1. The individual's needs mandate:

9 a. Skilled nursing care services; or

10 b. Skilled rehabilitative services; and

11 2. The care can only be provided on an inpatient basis;

12 (b) The inherent complexity of a service prescribed for an individual exists to the extent  
13 that it can be safely or effectively performed only by or under the supervision of technical or  
14 professional personnel; or

15 (c) The individual has an unstable medical condition manifesting a combination of care  
16 needs in the following areas:

17 1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intra-  
18 venous feeding;

19 2. Nasogastric or gastrostomy tube feedings;

20 3. Nasopharyngeal and tracheotomy aspiration;

21 4. Recent or complicated ostomy requiring extensive care and self-help training;

22 5. In-dwelling catheter for therapeutic management of a urinary tract condition;

23 6. Bladder irrigations in relation to previously indicated stipulation;

24 7. Special vital signs evaluation necessary in the management of related conditions;

- 1 8. Sterile dressings;
- 2 9. Changes in bed position to maintain proper body alignment;
- 3 10. Treatment of extensive decubitus ulcers or other widespread skin disorders;
- 4 11. Receiving medication recently initiated, which requires skilled observation to deter-
- 5 mine desired or adverse effects or frequent adjustment of dosage; or
- 6 12. Initial phases of a regimen involving administration of medical gases.

7 (3) An individual with a stable medical condition manifesting a combination of at least  
8 two (2) [~~three (3)~~] of the following care-need categories shall be determined to meet nurs-  
9 ing facility level of care:

10 (a) Mobility. To demonstrate a care need in this category, an individual shall meet at  
11 least one (1) of the three (3) conditions listed below to satisfy this one (1) care-need cate-  
12 gory:

13 1. Assistance with wheelchair. The individual is incapable of propelling a manual wheel-  
14 chair using upper or lower extremities or incapable of operating a powered wheelchair in-  
15 dependently;

16 2. Changes in bed position or transfer. The individual is incapable of turning in bed or  
17 transferring to or from bed, chair or toilet without physical assistance being provided by  
18 another on an ongoing basis (at least three (3) times weekly); or

19 3. Ambulation. The individual requires standby assistance from at least one (1) person  
20 while walking;

21 (b) Physical or environmental management for confusion or agitation. The individual-re-  
22 quires staff intervention due to an established pattern of aggressive or disruptive behavior  
23 that presents a substantial physical risk to self or others;

24 (c) Must be fed. The individual is incapable of taking food from a plate to his or her

1 mouth without assistance of another person. Assistance includes the actual feeding of the  
2 individual or verbal assistance to the extent that, without continuous presence and repeti-  
3 tive verbal instructions to the individual, he or she would require to be fed;

4 (d) Assistance with going to bathroom or using bedpan for elimination. The individual  
5 requires the physical assistance of another person for elimination or to use a bedpan or to  
6 perform incontinence care, ostomy care, or catheter care on an ongoing basis (three (3) or  
7 more times each week);

8 (e) Administration of stabilized dosages of medication. The individual is not mentally-or  
9 physically capable of self-administration of prescribed medications despite the availability  
10 of limited assistance of another person. Limited assistance shall include reminding when to  
11 take medications, filling a medication box, encouragement to take medications, reading  
12 labels, and opening bottles;

13 (f) Requires restorative and supportive nursing care to maintain the individual and pre-  
14 vent deterioration of his or her condition by means of a planned program administered by  
15 nursing staff, such as range of motion exercises and application of splints, when pre-  
16 scribed, that the patient is unable to apply by him or herself;

17 (g) Administration or preparation of injections by licensed personnel, either due to the  
18 nature of the injection or due to the inability of the individual. An individual shall have a  
19 physical or mental limitation that prevents him or her from preparing or self-administering  
20 injections even with appropriate training;

21 (h) Services that could ordinarily be provided or administered by the individual but due  
22 to the individual's physical or mental condition, the individual is incapable of providing self-  
23 care. This shall include daily total hands-on assistance with bathing, dressing, or grooming  
24 by a person other than the individual; or

1 (i) Cognition and communication. The individual is disoriented as to self or place or is  
2 incapable of communicating basic needs and wants (such as need for assistance with toi-  
3 leting, presence of pain) using oral or written language. Illiteracy shall not meet this re-  
4 quirement.

5 (4) An individual shall not be considered to meet nursing facility level of care criteria if  
6 care needs are limited to:

7 (a) Limited assistance with activities of daily living, for example, bathing, dressing, or  
8 grooming;

9 (b) Independent use of mechanical devices; for example, assistance in mobility by  
10 means of a wheelchair, walker, crutch or cane;

11 (c) A limited diet, for example, low salt, low residue, reducing or another minor restrictive  
12 diet;

13 (d) Medications or therapies that can be self-administered or the individual requires  
14 minimal supervision;

15 (e) General supervision;

16 (f) Routine use of oxygen (as needed, continuous, or at night); or

17 (g) Limited ability to perform instrumental activities of daily living (IADL), for example,  
18 meal preparation, homemaking, or doing laundry.

19 (5) An individual with a mental illness, mental retardation, or a developmental disability  
20 meeting the health status and care needs specified in this section shall:

21 (a) Be considered to meet nursing facility level of care criteria; and

22 (b) Be specifically excluded from coverage in the following situations:

23 1. If the department determines that in the individual case the combination of care needs  
24 are beyond the capability of the facility, and that placement in the facility is inappropriate

1 due to potential danger to the health and welfare of the individual, other patients in the facil-  
2 ity, or staff of the facility;

3 2. If the nursing care needs result directly and specifically from a mental illness, mental  
4 retardation, or a developmental disability; or

5 3. If the individual does not meet the preadmission screening and resident review crite-  
6 ria specified in 42 U.S.C. 1396r and 907 KAR 1:755 for entering or remaining in a facility.

7 (6) Transfer trauma criteria. A Medicaid recipient who does not meet the nursing facility  
8 level of care criteria established in subsection (3) of this Section shall not be discharged  
9 from an NF if:

10 (a) The recipient has resided in an NF for at least eighteen (18) consecutive months;

11 (b) The recipient's attending physician determines that the recipient would suffer transfer  
12 trauma in that his or her physical, emotional or mental well being would be compromised by  
13 a discharge action as a result of not meeting NF level of care criteria; and

14 (c) The department confirms the recipient's attending physician's assessment regarding  
15 the trauma caused by possible discharge from the NF.

16 (7) A Medicaid recipient who meets transfer trauma criteria in accordance with subsec-  
17 tion (6) of this Section:

18 (a) Shall remain in an NF and continue to be covered by the department for provider re-  
19 imbursement at least until his or her subsequent transfer trauma assessment; and

20 (b) Be reassessed for transfer trauma every six (6) months.

21 Section 5. Determining ICF-MR-DD Level of Care. An individual shall be determined to  
22 meet ICF-MR-DD level of care for an ICF-MR-DD if the individual requires physical or envi-  
23 ronmental management or rehabilitation for moderate to severe retardation. In making the  
24 decision as to ICF-MR-DD level of care, the following criteria shall apply:

1 (1) An individual with significant developmental disabilities or significantly subaverage  
2 intellectual functioning who requires a planned program of active treatment to attain or  
3 maintain the individual's optimal level of functioning but does not necessarily require NF or  
4 NF-W services, shall be considered to meet ICF-MR-DD level of care.

5 (2) An individual requiring a protected environment while overcoming the effects of de-  
6 velopmental disabilities or subaverage intellectual functioning shall be considered to meet  
7 ICF-MR-DD level of care while:

8 (a) Learning fundamental living skills;

9 (b) Learning to live happily and safely within his or her own limitations;

10 (c) Obtaining educational experiences that will be useful in self-supporting activities; or

11 (d) Increasing his or her awareness of his or her environment.

12 (3) An individual with a psychiatric primary diagnosis or needs shall be considered to  
13 meet ICF-MR-DD level of care if:

14 (a) The individual also has care needs as described in subsection (1) or (2) of this sec-  
15 tion;

16 (b) His or her mental care needs can be adequately handled in an ICF-MR-DD; and

17 (c) He or she does not require psychiatric inpatient treatment.

18 (4) An individual who does not require a planned program of active treatment to attain or  
19 maintain his or her optimal level of functioning shall not be considered to meet ICF-MR-DD  
20 level of care.

21 (5) An individual shall not be denied ICF-MR-DD level of care solely due to advanced  
22 age, length of stay in an institution, or history of previous institutionalization, if the individual  
23 qualifies for ICF-MR-DD level of care on the basis of all other factors.

24 (6) Excluding an individual with mental retardation, for an individual with a developmental

1 disability, the disability shall have manifested itself prior to the individual's 22nd birthday.

2 Section 6. Reevaluation of Need for Service. (1) Nursing facility, nursing facility with  
3 waiver, or ICF-MR-DD services shall continue to be provided to an individual if his or her  
4 health status and care needs are within the scope of program benefits as described in  
5 Sections 3, 4 and 5 of this administrative regulation.

6 (2) The nursing facility or ICF-MR-DD level of care status of an individual shall be re-  
7 evaluated at least once every six (6) months.

8 Section 7. Requirements, Standards and Preauthorization of Specialized Rehabilitation  
9 Services for Individuals with Brain Injuries. An individual who is brain injured and meets the  
10 nursing facility level of care criteria or is qualified under subsection (5) of this section shall  
11 be provided care in a certified unit providing specialized rehabilitation services for persons  
12 with brain injuries (i.e., brain injury unit) if the care is preauthorized by the department using  
13 criteria specified in this section. For coverage to occur, authorization of coverage shall be  
14 granted prior to admission of the individual with the brain injury into the certified brain injury  
15 unit, or if previously admitted to the unit with other third party coverage, authorization shall  
16 be granted prior to exhaustion of those benefits.

17 (1) Injuries within the scope of benefits shall be:

18 (a) Central nervous system injury from physical trauma;

19 (b) Central nervous system damage from anoxia or hypoxic episodes; or

20 (c) Central nervous system damage from an allergic condition, toxic substance or an-  
21 other acute medical or clinical incident.

22 (2) The following items shall be indicators for admission and continued stay:

23 (a) The individual sustained a traumatic brain injury with structural, nondegenerative  
24 brain damage and is medically stable;

- 1 (b) The individual shall not be in a persistent vegetative state;
- 2 (c) The individual demonstrates physical, behavioral, and cognitive rehabilitation poten-  
3 tial;
- 4 (d) The individual requires coma management; or
- 5 (e) The individual has sustained diffuse brain damage caused by anoxia, toxic poison-  
6 ing, or encephalitis.
- 7 (3) The determination as to whether preauthorization is appropriate shall be made tak-  
8 ing into consideration the following:
- 9 (a) The presenting problem;
- 10 (b) The goals and expected benefits of the admission;
- 11 (c) The initial estimated time frames for goal accomplishment; and
- 12 (d) The services needed.
- 13 (4) The following list of conditions shall not be considered brain injuries requiring spe-  
14 cialized rehabilitation under this section:
- 15 (a) A stroke treatable in a nursing facility providing routine rehabilitation services;
- 16 (b) A spinal cord injury in which there is no known or obvious injury to the intercranial  
17 central nervous system;
- 18 (c) Progressive dementia or other mentally impairing condition;
- 19 (d) Depression or psychiatric disorder in which there is no known or obvious central  
20 nervous system damage;
- 21 (e) Mental retardation or birth defect related disorder of long standing; or
- 22 (f) Neurological degenerative, metabolic or other medical condition of a chronic, degen-  
23 erative nature.
- 24 (5) An individual may qualify for coverage under the brain injury program if:

1 (a) He or she has a stable medical condition with complicating care needs which pre-  
2 vent the individual from caring for him or herself in an ordinary manner outside an institu-  
3 tion;

4 (b) The individual has sufficient neurobehavioral sequelae resulting from the brain injury  
5 which when taken in combination require specialized rehabilitation services; and

6 (c) if the following criteria are met:

7 1. The individual shall not have previously received specialized rehabilitation services  
8 (an individual discharged for the purpose of transfer to another brain injury facility shall not  
9 be considered to have "previously received specialized rehabilitation services") as estab-  
10 lished in this section;

11 2. The individual shall have the potential for rehabilitation;

12 3. The care shall be prior authorized on an individual basis by the department; and

13 4. The care shall be authorized for no more than six (6) months at any one (1) time.

14 Section 8. Requirements, Standards and Preauthorization of Certified Distinct-part  
15 Nursing Facility Ventilator Services. An individual who is ventilator dependent and requires  
16 the skilled nursing care services established in Section 4(2) of this administrative regula-  
17 tion criteria shall be provided care in a certified distinct-part ventilator nursing facility unit  
18 providing specialized ventilator services if the care is preauthorized using criteria specified  
19 in this section and the Medicaid Nursing Facility Services Manual.

20 (1) To participate in the Medicaid Program as a distinct-part nursing facility ventilator  
21 service provider:

22 (a) A nursing facility shall operate a program of ventilator care within a certified distinct-  
23 part nursing facility unit which meets the needs of all ventilator patients admitted to the unit;

24 and

- 1 (b) A certified distinct-part nursing facility unit shall:
- 2 1. Not have less than twenty (20) beds certified for the provision of ventilator care;
- 3 2. Be required to have an average patient census of not less than fifteen (15) patients
- 4 during the calendar quarter preceding the beginning of the facility's rate year or the quarter
- 5 for which certification is being granted in order to qualify as a distinct-part ventilator nursing
- 6 facility unit;
- 7 3. Have a ventilator machine owned by the facility for each certified bed with an addi-
- 8 tional backup ventilator machine required for every ten (10) beds; and
- 9 4. Have an appropriate program for discharge planning and weaning from the ventilator.

10 (2) The following items shall be the patient criteria and treatment characteristics for a

11 distinct-part ventilator nursing facility:

12 (a) An individual shall be considered ventilator (or respiration stimulating mechanism)

13 dependent if the individual:

14 1. Requires:

15 a. This mechanical support for twelve (12) or more hours per day; and

16 b. Twenty-four (24) hours per day skilled specialty nursing care; or

17 2. Is in an active weaning program ordered by and under the management of a physi-

18 cian and reviewed and approved by the department; and

19 a. The goal of the active weaning program is to attain the least mechanical support in

20 the least invasive manner that is consistent with the maximal function of the individual and

21 ultimately no mechanical respiratory support;

22 b. The individual demonstrates steady progress in decreasing the number of hours and

23 dependence upon the ventilator (or respiration stimulating mechanism) as documented in

24 the individual's physician and nursing progress notes; and

1 c. The individual requires twenty-four (24) hours per day skilled specialty nursing care.

2 (b) An individual shall not be considered ventilator dependent due to being in an active  
3 weaning program if:

4 1. The individual is no longer demonstrating steady progress in decreasing the number  
5 of hours and dependence upon the ventilator (or respiration stimulating mechanism); or

6 2. The individual has been off the ventilator (or respiration stimulating mechanism) for  
7 seventy-two (72) consecutive hours.

8 (c) An admission from hospitalization or other location shall demonstrate two (2) weeks  
9 clinical and physiologic stability including applicable weaning attempts prior to transfer.

10 (d) A physician's order shall specify that the services shall not be provided in an alterna-  
11 tive setting due to the medical stability and safety needs of the individual.

12 (3) A nursing facility level of care determination shall be made taking into consideration  
13 the following factors and those defined in the Medicaid Nursing Facility Services Manual,  
14 Section IV -B, C and D:

15 (a) Alternative care possibilities;

16 (b) Goals for patient care;

17 (c) Primary hypoventilation, restrictive lung, ventilatory muscular dysfunction, or obstruc-  
18 tive airway disorders needs which may necessitate mechanical ventilator and related care;

19 (d) Nonhospital management factors and needs;

20 (e) Patient treatment characteristics;

21 (f) Home care potential;

22 (g) Suitability of transfer to the ventilator care unit;

23 (h) Provision of an appropriate place of care; and

24 (i) Other facility admission indicators as established in the Medicaid Nursing Facility

1 Services Manual.

2 Section 9. Denial of Nursing Facility and ICF-MR-DD Level of Care. If an individual does  
3 not meet Medicaid criteria for admission or continued stay in a nursing facility or ICF-MR-  
4 DD, the individual may appeal the denial in accordance with 907 KAR 1:563.

5 Section 10. Reserved Bed Days. The department shall cover reserved bed days in ac-  
6 cordance with the following criteria.

7 (1) In accordance with subsection (3) of this section, reserved bed days, per resident,  
8 for an NF or an NF-W shall be covered for a maximum of:

9 (a) Fourteen (14) days per temporary absence due to hospitalization, with an overall  
10 maximum of forty-five (45) days during a calendar year; and

11 (b) Fifteen (15) days during a calendar year for leaves of absence other than hospitaliza-  
12 tion.

13 (2) In accordance with subsection (3) of this section, for an ICF-MR-DD:

14 (a) Reserved bed days, per resident, for an ICF-MR-DD shall:

15 1. Be covered for a maximum of forty-five (45) days per provider within a calendar quar-  
16 ter; and

17 2. Not exceed fifteen (15) days per stay due to hospitalization; and

18 (b) More than thirty (30) consecutive reserved bed days due to hospitalization plus leave  
19 of absence or due to leave of absence shall not be approved for coverage.

20 (3) Coverage during an individual's absence due to hospitalization or due to leave of  
21 absence shall be contingent upon the following conditions being met:

22 (a) The individual shall:

23 1. Be in Medicaid payment status in the level of care he or she is authorized to receive;

24 and

1       2. Have been a resident of the facility at least overnight;

2       (b) An individual for whom Medicaid is making Medicare coinsurance payments shall  
3 not be considered to be in Medicaid payment status for purposes of this policy;

4       (c) The individual shall be reasonably expected to return to the same level of care;

5       (d) Due to demand at the facility for beds at that level, there shall be a likelihood that the  
6 bed would be occupied by another patient were it not reserved;

7       (e) The hospitalization shall be for treatment of an acute condition, and not for testing,  
8 brace-fitting, or another noncovered service;

9       (f) For a leave of absence other than for hospitalization, the individual's plan of care shall  
10 include a physician's order providing for leave; and

11       (g) A leave of absence shall include a visit with a relative or friend, or a leave to partici-  
12 pate in a state-approved therapeutic or rehabilitative program.

13       Section 11. Preadmission Screening and Resident Review. (1) Prior to admission of an  
14 individual, an NF shall conduct a level I PASRR in accordance with 907 KAR 1:755, Sec-  
15 tion 4.

16       (2) Compliance with 907 KAR 1:755 shall be required in order for an individual to be  
17 admitted to an NF.

18       Section 12. Incorporation by Reference. (1) "Medicaid Nursing Facility Services Man-  
19 ual", Department for Medicaid Services, January 2004 [~~April 2003~~] edition, is incorporated  
20 by reference.

21       (2) It may be inspected, copied, or obtained, subject to applicable law, at the Depart-  
22 ment for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday  
23 through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:022E

Reviewed:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mike Robinson, Commissioner  
Department for Medicaid Services

APPROVED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
James. W. Holsinger, Jr., M.D.  
Cabinet for Health and Family Services

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:022E  
Cabinet for Health Services  
Department for Medicaid Services  
Agency Contact Person: Stuart Owen or Teresa Goodrich (564-6204)

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes the nursing facility (NF) and intermediate care facility for an individual with mental retardation or a developmental disability (ICF MR DD) level of care criteria as well as the establishes the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary in order to establish the NF and ICF MR DD level of care criteria as well as to establish the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of authorizing statutes by establishing the NF and ICF MR DD level of care criteria as well as by establishing the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of statutes by establishing the NF and ICF MR DD level of care criteria as well as by establishing the provisions relating to NF and ICF MR DD services for which payment shall be made by the Medicaid Program on behalf of both the categorically needy and medically needy recipients.
  
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
  - (a) How the amendment will change this existing administrative regulation: The qualifying requirements regarding NF level of care are being relaxed. An individual will now need to meet two (2) of nine (9) rather than three (3) of nine (9) NF level of care criteria and an individual who is determined to meet transfer trauma criteria shall not be discharged from an NF. This action is being taken to enable DMS to maximize the number of medically needy recipients to be served by the nursing facility and home and community based (HCB) waiver service programs with the limited resources available to DMS.
  - (b) The necessity of the amendment to this administrative regulation: The amendment to this administrative regulation is necessary to enable DMS to maximize the number of medically needy recipients to be served by the nursing facility and home and community based HCB waiver service programs with the limited resources available to DMS.

- (c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation conforms to the content of authorizing statutes by revising qualifying requirements regarding NF level of care in order to enhance recipient access to services within the limited resources available to DMS.
  - (d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation will assist in the effective administration of the statutes by revising qualifying requirements regarding NF level of care in order to enhance recipient access to services within the limited resources available to DMS.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Approximately 275 nursing facilities serving over 16,000 Medicaid recipients currently participate in the Medicaid nursing facility program and approximately 115 home and community based waiver providers serve over 15,000 individuals via the Medicaid home and community based waiver program.
  - (4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: It is difficult to determine the number of individuals who will be impacted by the amendment to this administrative regulation; however, DMS estimates that nursing facility denials will drop from approximately twenty (20) a month to approximately five (5) a month as a result of this amendment. Home and community based waiver denials are estimated to drop from approximately 220 a month to approximately 70 a month.
  - (5) Provide an estimate of how much it will cost to implement this administrative regulation:
    - (a) Initially: DMS estimates that the amendment to this administrative regulation will result in a cost of approximately \$5.77 million annually (\$4.21 million federal funds; \$1.56 million state funds).
    - (b) On a continuing basis: DMS estimates that the amendment to this administrative regulation will result in a cost of approximately \$5.77 million annually (\$4.21 million federal funds; \$1.56 million state funds).
  - (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of revenue to be utilized to implement and enforce this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.
  - (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding will be necessary to implement the amendments to this administrative regulation.
  - (8) State whether or not this administrative regulation establishes any fees or directly or

indirectly increases any fees: This administrative regulation does not establish any fees nor directly or indirectly increase any fees.

- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)  
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The “equal protection” and “due process” clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

## FEDERAL MANDATE ANALYSIS COMPARISON

Reg. No. 907 KAR 1:022E

Agency Contact: Stuart Owen or Teresa Goodrich at  
502-564-6204

1. Federal statute or regulation constituting the federal mandate.

Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

2. State compliance standards.

This administrative regulation revises the Department for Medicaid Services qualifying requirements regarding nursing level of care.

3. Minimum or uniform standards contained in the federal mandate.

This administrative regulation revises the Department for Medicaid Services qualifying requirements regarding nursing level of care.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

No. This administrative regulation does not set stricter requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

No additional standard or responsibilities are imposed.

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:022E  
Summary of Material Incorporated by Reference

The Medicaid Nursing Facility Services Manual (January 2004 edition) which is being revised is used by agency staff and participating providers. The manual contains 155 pages. It is divided into five sections and also an appendix which includes provider forms.

Section III – Conditions of Participation – deleted the requirement for level of care recertification upon readmission to a nursing facility when a Medicaid recipient has left the facility due to an acute care hospital stay for three (3) or more days.

Section IV - Program Coverage, language regarding requirements for nursing facility level of care criteria was amended to make the manual consistent with the regulation and transfer trauma criteria language was added to the manual to render it consistent with the regulation

Appendix

The following form is new and is being added to the material incorporated by reference: “MAP-4105, Application for Transfer Trauma Exemption, January 23, 2004 edition”.

This is a new form to be utilized by attending physicians to document whether or not a Medicaid recipient meet transfer trauma criteria. It shall be completed by a recipient’s attending physician and submitted to the department. This is a one (1) page form.

The “MAP-726, Nursing Facility Request for Admission, April 2002 edition” has been replaced by the “MAP-726A, Nursing Facility Level of Care Request for Admission, September 2003 edition”. The formerly four (4) – page form is now a seven (7) - page form and is utilized to request admission of an individual into a nursing facility. The form has been reformatted and a segment addressing nursing rehabilitative/restorative care has been added to the form.