907 KAR 1:780. Converted dual-licensed hospital-based nursing facility beds.

RELATES TO: KRS 216B.020(4), (5)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 216B.075, EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services has the responsibility for administering the Kentucky Medicaid Program in an efficient, cost-effective manner, consonant with the funds that are available, and consistent with the objectives of the Program. One (1) of these objectives is for recipients to have reasonable access to health care and services under the Medicaid Program, taking into account such factors as geographic location, travel time, choice of providers, and utilization rates. This administrative regulation establishes the process and criteria relating to Medicaid participation for dual-licensed acute care hospital beds that were converted to nursing facility beds pursuant to KRS 216B.020(4), and supplements applicable provisions for provider enrollment in Section 2 of 907 KAR 1:672 and the administrative hearing process in 907 KAR 1:671.

Section 1. Definitions. (1) "Administrative process" means meeting, review, investigation, hearing, appeal, deliberation or exchange of documents or information between the provider and the department.

(2) "Applicant" means a person or entity who submits an application to become a Medicaid provider.

(3) "Applicant’s geographic area" means the county in which the applicant’s converted dual-licensed hospital-based nursing facility beds are located and contiguous Kentucky counties.

(4) "Application" means a request for Medicaid certification for beds that were converted to hospital-based nursing facility beds pursuant to KRS 216B.020(4).

(5) "Certificate of need" is defined in KRS 216B.015(8).

(6) "Converted" means a bed that was previously a dual-licensed acute care hospital bed that, pursuant to KRS 216B.020(4) and (5), changed a dual-licensed acute care bed to a hospital-based nursing facility bed and is not presently participating in the Medicaid Program.

(7) "Provider" is defined in KRS 205.8451(7).

(8) "State Health Plan" is defined in KRS 216B.015(19).

Section 2. Enrollment Process for Converted Dual-Licensed Hospital-Based Nursing Facility Beds Participation in Medicaid. (1) An application for converted dual-licensed hospital-based nursing facility beds which are not presently participating in the Medicaid Program, but requesting participation, shall be submitted to the Commissioner of the Department for Medicaid Services.

(a) The application shall be in writing in the form, content and manner required by the department in accordance with this administrative regulation and 907 KAR 1:672. The application shall contain the following, with pertinent information and supporting documentation:

1. The total number, each room number and bed designation of:

a. Dual-licensed acute care beds that were converted to hospital-based nursing facility beds and licensed pursuant to KRS 216B.020(4);

b. Converted beds already participating in Medicaid;

c. Converted hospital-based nursing facility beds applying for Medicaid certification; and

d. Licensed hospital-based nursing facility beds.

2. Data that demonstrates a need for additional not presently participating Medicaid certified beds in the applicant's geographic area in accordance with the factors listed in Section 3 of this administrative regulation;

3. The requested date for Medicaid certification of the converted beds; and

(b) Information in the application shall be current, presented clearly and precisely.

(2) The department shall:

(a) Review the application for completeness; and

(b) Review the notification from the Division of Licensing and Regulation of the Office of Inspector General recommending Medicaid certification for the converted beds.

(3) Upon receipt of notification from the Division of Licensing and Regulation, along with a complete and accurate application, with all requested documentation, the department shall determine:

(a) The number of licensed hospital-based nursing facility beds the applicant has available for certification; and

(b) Whether the application establishes a need for additional Medicaid certified beds in the applicant's geographic area in accordance with Section 3 of this administrative regulation.

(4) Except as provided in subsection (9) of this section, the department shall make a decision regarding the application within thirty (30) days of the receipt of information specified in subsection (3) of this section. The department shall:

(a) Grant, in whole or in part, the requested Medicaid certification; or

(b) Deny the request.

(5) The department shall notify the applicant, in writing, of the decision, and the basis for denial if applicable.

(6) If an applicant wishes to appeal an adverse determination, the appeal shall be in accordance with Sections 4 and 5 of this administrative regulation.

(7) Except as provided in subsection (8) of this section, if an application for Medicaid certification of converted beds is fully or partially granted and the applicant is not currently a Medicaid certified nursing facility provider, the applicant shall:

(a) Follow the enrollment procedures delineated in 907 KAR 1:672; and

(b) Include a copy of the department's decision granting certification in its enrollment packet.

(8) If the applicant is currently a Medicaid certified nursing facility provider:

(a) All converted beds that may be certified by the department shall be included under the existing provider number; and

(b) The provider shall comply with licensing requirements established in 902 KAR 20:300 and 902 KAR 20:310.

(9) Subsection (4) of this section shall:

(a) Apply to a request for new participation in the Medicaid Program; and

(b) Not apply to a bed previously approved by the department.

Section 3. Enrollment Criteria for Converted Dual-Licensed Hospital-Based Nursing Facility Beds Requesting Participation in Medicaid. (1) Based on data submitted in the application, relevant factors in the applicant's geographic area shall be considered to assess the need for Medicaid certification of converted beds and shall include:

(a) The total number of free-standing and hospital-based nursing facility beds.

(b) The total number of the following:

1. Medicaid certified nursing facility beds; and

2. Medicaid certified hospital-based nursing facility beds;

(c) Survey data reported to the cabinet by providers for the two (2) calendar years preceding the date of receipt of the application, and data collected by the cabinet in accordance with 902 KAR 20:008 for licensed nursing facility beds in the applicant's geographic area relating to:

1. The occupancy percentage for each of the two (2) preceding calendar years; and

2. The number of admissions, discharges or deaths;

(d) The impact of the cost of the converted beds on the Medicaid budget;

(e) The current State Health Plan "nursing facility bed need calculations by county and state" maintained by the Cabinet for Health and Family Services, Office of the Certificate of Need; and

(f) Other documentation included in the application that demonstrates the need for Medicaid certification of a converted bed.

(2) The department may consider the following when making a determination of need:

(a) The most current Medicaid nursing facility financial data; and

(b) Other information, including relevant information that the department may have requested from:

1. The applicant;

2. Another provider in the applicant's geographic area; or

3. A medical services trend report.

Section 4. Resolution of Applicant Disputes Prior to an Administrative Hearing. (1) If an applicant disagrees with the department's determination regarding Medicaid certification, the applicant may:

(a) Request a resolution meeting pursuant to subsections (2), (3), and (4) of this section; or

(b) Submit additional information for consideration in lieu of a request pursuant to subsection (5) of this section.

(2) A written request for a resolution meeting shall be received by the Director of the Department's Division of Long-term Care within thirty (30) calendar days of the date of the department's notice of decision. The request shall:

(a) Identify the disputed issue or issues;

(b) State the basis of the challenge to the department's decision;

(c) Provide documentation supporting the applicant's position; and

(d) State the name, address, and telephone number of an individual expected to attend the resolution meeting on the applicant's behalf.

(3) The department shall, within thirty (30) calendar days of receipt of a request for resolution meeting, send written notice to the applicant of the date, time and place of the meeting.

(4) The resolution meeting shall be conducted by the department in an informal manner. The applicant or the department may present relevant evidence or testimony at the meeting in support of their respective positions.

(5) In lieu of requesting a resolution meeting, an applicant may submit additional information it wishes the department to consider.

(a) The additional information shall be received by the department within thirty (30) days of notice of the department's decision; and

(b) The submission of additional documentation shall not:

1. Constitute a request for a resolution meeting; and

2. Extend the thirty (30) day time period for requesting a resolution meeting.

(6) The department may rescind, modify or take no action with regard to its initial adverse decision.

(a) The department shall provide written notice to the provider of the department's decision within thirty (30) calendar days from:

1. The date of the resolution meeting; or

2. The date additional information was received for consideration.

(b) The notice shall state the decision and the facts on which it is based, including references to applicable statutes and administrative regulations.

(7) The department may extend a time frame specified in this section, upon written notice to the applicant, if an extension:

(a) Is determined to be necessary for the efficient administration of the resolution meeting process; or

(b) Is needed to prevent a miscarriage of justice with regard to the provider.

Section 5. Administrative Hearing Process. An applicant may appeal an adverse decision rendered by the department. An appeal shall be in accordance with the provisions established in 907 KAR 1:671, Section 9(1) and (3) through (14). (25 Ky.R. 2080; 2629; 26 Ky.R. 65; eff. 8-18-1999; Crt eff. 7-23-2018.)