

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Health Care Policy

(Amendment)

907 KAR 1:022. Nursing facility services and intermediate care facility for individuals with an intellectual disability services.

RELATES TO: 42 C.F.R. 431.153, 431.154, 435.1010, 447.280, 482.58, 42 U.S.C. 1395tt, 1396l, 1396r

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.558

CERTIFICATION STATEMENT:

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the provisions relating to nursing facility services and services at an intermediate care facility for individuals with an intellectual disability for which payment shall be made by the Medicaid program on behalf of both the categorically needy and medically needy recipients.

Section 1. Definitions.

- (1) "Department" means the Department for Medicaid Services or its designee.
- (2) "Department approved system" means a technology system in which:
 - (a) Providers electronically submit and track level of care (LOC) requests through a self-service portal;
 - (b) The system triggers LOC tasks as reminders to providers and allows them to submit reassessments electronically; and
 - (c) Information is exchanged electronically with Kentucky's:
 1. Medicaid Enterprise Management Solution (MEMS); and
 2. Integrated eligibility and enrollment system.
- (3) "High-intensity nursing care services" means care provided:
 - (a) To a Medicaid-eligible individual who meets high-intensity nursing care patient status criteria in accordance with Section 4 of this administrative regulation; and
 - (b) By a nursing facility or a nursing facility with Medicaid waiver participating in the Medicaid program with care provided in beds also participating in the Medicare program.
- (4) "High-intensity rehabilitation services" means therapy services that:
 - (a) Are expected to improve an individual's condition while the individual possesses reasonable potential for improvement in functional capability; and
 - (b) Do not include restorative and maintenance nursing procedures, including routine range of motion exercises and application of splints or braces by nurses and staff.
- (5) "Intermediate care facility for individuals with an intellectual disability" or "ICF-IID" means a licensed intermediate care facility for individuals with an intellectual disability certified by the Department for Medicaid Services as meeting all standards for an intermediate care facility for individuals with an intellectual disability.
- (6) "Intermediate care facility for individuals with an intellectual disability services" or "ICF-IID services" means care provided:
 - (a) To a Medicaid-eligible individual who meets ICF-IID patient status criteria in accordance with Section 4 of this administrative regulation; and
 - (b) By an ICF-IID participating in the Medicaid program.

(7) "Intermittent high-intensity nursing care services" means services for an individual who requires high-intensity nursing care services at regular or irregular intervals, but not on a twenty-four (24) hour-per-day basis and not less than three (3) calendar days per week.

(8) "Low-intensity nursing care services" means care provided:

(a) To a Medicaid-eligible individual who meets low-intensity nursing care patient status criteria in accordance with Section 4 of this administrative regulation; and

(b) By a nursing facility or a nursing facility with Medicaid waiver participating in the Medicaid program.

(9) "Medical condition" means a state of health relative to a clinical diagnosis made by a licensed physician, physician assistant, advanced practice registered nurse, or a qualified behavioral health professional.

(10) "Nursing facility" or "NF" means:

(a) A facility:

1. To which the Cabinet for Health and Family Services, Office of Inspector General, has granted an NF license;

2. For which the Cabinet for Health and Family Services, Office of Inspector General, has recommended to the department certification as a Medicaid provider; and

3. To which the department has granted certification for Medicaid participation; or

(b) A hospital swing bed that provides services in accordance with 42 U.S.C. 1395tt and 1396l, if the swing bed is certified to the department as meeting requirements for the provision of swing bed services in accordance with 42 U.S.C. 1396r(b), (c), (d), 42 C.F.R. 447.280 and 482.58.

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

(a) To which the Cabinet for Health and Family Services, Office of Inspector General, has granted an NF license;

(b) For which the Cabinet for Health and Family Services, Office of Inspector General, has recommended to the department certification as a Medicaid provider;

(c) To which the department has granted a waiver of the nurse staffing requirement; and

(d) To which the department has granted certification for Medicaid participation.

(12) "Patient status" means an individual's level of care in accordance with Section 4 of this administrative regulation for treatment in an institutional setting.

(13) "Personal care" means services to help an individual achieve and maintain good personal hygiene, which may include assistance with bathing, shaving, cleaning and trimming of fingernails and toenails, cleaning of the mouth and teeth, washing, and grooming and cutting of hair.

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

Section 2. Participation Requirements. A facility desiring to participate in the Medicaid program as a nursing facility, nursing facility with Medicaid waiver, or ICF-IID shall meet the requirements established in this section.

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

(2)

(a) Except as provided by paragraph (b) of this subsection or for a nursing facility with Medicaid waiver, a nursing facility shall have at least twenty (20) percent of all

Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare.

(b) If a nursing facility has less than ten (10) beds certified for Medicaid, all Medicaid certified beds shall also be certified to participate in Medicare.

(3)

(a) Except as provided by paragraph (b) of this subsection, if a nursing facility with Medicaid waiver chooses to participate in Medicare, the facility shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare.

(b) If a nursing facility with Medicaid waiver has less than ten (10) beds certified for Medicaid, all Medicaid beds shall also be certified to participate in Medicare.

(4) A nursing facility or a nursing facility with Medicaid waiver shall comply with the preadmission screening and resident review requirements specified in 42 U.S.C. 1396r and 907 KAR 1:755. A facility failing to comply with these requirements shall be subject to disenrollment, with exclusion from participation to be accomplished in accordance with 907 KAR 1:671, 42 C.F.R. 431.153, and 42 C.F.R. 431.154.

(5) A facility shall be certified by the Cabinet for Health and Family Services, Office of Inspector General, as meeting NF, NF-W, or ICF-IID status.

(6) In order to provide specialized rehabilitation services to an individual with a brain injury in accordance with Section 6 of this administrative regulation, a facility shall be accredited by:

(a) The Joint Commission;

(b) The Commission on Accreditation of Rehabilitation Facilities;

(c) The Council on Accreditation; or

(d) A nationally recognized accreditation organization.

(7) A participating nursing facility shall be certified in accordance with standards and conditions specified in this administrative regulation before the facility may operate a unit that provides:

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

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

(8) A participating nursing facility, nursing facility with Medicaid waiver, or ICF-IID shall enter a resident's discharge date into a department approved system.

(9)

(a) A licensed swing bed facility shall contact the department for a new level of care review prior to swinging the bed back to nursing facility status if the bed swings to acute status for three (3) or more consecutive calendar days.

(b) An NF shall not count the day the bed will swing back to nursing facility status in the three (3) consecutive days specified in paragraph (a) of this subsection.

Section 3. Payment Provisions.

(1) Payment for high-intensity nursing care, low-intensity nursing care, or ICF-IID services shall be limited to those services meeting the care definitions established in Section 1 of this administrative regulation.

(2) An NF or NF-W shall receive payment for high-intensity nursing care services provided to a Medicaid-eligible individual meeting high-intensity nursing care patient status criteria if the services are provided in a Medicaid participating bed that is also participating in the Medicare program.

(3) An NF or NF-W shall receive payment for low-intensity nursing care services provided to a Medicaid-eligible individual meeting low-intensity nursing care patient status criteria if the services are provided in a Medicaid participating bed.

(4) An ICF-IID shall receive payments for ICF-IID services only.

Section 4. Patient Status Criteria. A patient status decision shall be based on medical diagnosis, care needs, services and health personnel required to meet these needs, and the feasibility of meeting the needs through alternative institutional or noninstitutional services.

(1) For an admission and continued stay, an individual shall qualify under the preadmission screening and resident review criteria specified in 42 U.S.C. 1396r and 907 KAR 1:755.

(2) An individual shall be considered to meet the level of care criteria for high-intensity nursing care if:

(a) On a daily basis:

1. The individual's needs mandate:

- a. High-intensity nursing care services; or
- b. High-intensity rehabilitation services; and

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

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

(c) The individual has an unstable medical condition manifesting a combination of at least two (2) or more care needs in the following areas:

- 1. Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;
- 2. Nasogastric or gastrostomy tube feedings;
- 3. Nasopharyngeal and tracheotomy aspiration;
- 4. Recent or complicated ostomy requiring extensive care and self-help training;
- 5. In-dwelling catheter for therapeutic management of a urinary tract condition;
- 6. Bladder irrigations in relation to previously indicated stipulation;
- 7. Special vital signs evaluation necessary in the management of related conditions;
- 8. Sterile dressings;
- 9. Changes in bed position to maintain proper body alignment;
- 10. Treatment of extensive decubitus ulcers or other widespread skin disorders;
- 11. Receiving medication recently initiated, which requires high-intensity observation to determine desired or adverse effects or frequent adjustment of dosage;
- 12. Initial phases of a regimen involving administration of medical gases; or
- 13. Receiving services that would qualify as high-intensity rehabilitation services if provided by or under the supervision of a qualified therapist, for example:
 - a. Ongoing assessment of rehabilitation needs and potential;
 - b. Therapeutic exercises;
 - c. Gait evaluation and training performed by or under the supervision of a qualified physical therapist;
 - d. Range of motion exercises that are part of the active treatment of a specific disease state that has resulted in a loss of, or restriction of, mobility;
 - e. Maintenance therapy if the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs and consistent with the patient's capacity and tolerance;
 - f. Ultrasound, short wave, and microwave therapy treatments;
 - g. Hot pack, hydrocollator infrared treatments, paraffin baths, and whirlpool (if the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified therapist are required); or
 - h. Services by or under the supervision of a speech-language pathologist or audiologist if necessary for the restoration of function in speech or hearing.

(3)

(a) An individual shall be considered to meet the level of care criteria for low-intensity patient status if, unrelated to age appropriate dependencies with respect to a minor, the individual meets the requirements of this paragraph:

1. An individual with a stable medical condition requiring intermittent high-intensity nursing care services not provided in a personal care home shall be considered to meet low-intensity patient status;
2. An individual with a stable medical condition, who has a complicating problem that prevents the individual from caring for himself or herself in an ordinary manner outside the institution, shall be considered to meet low-intensity patient status. For example, an ambulatory cardiac patient with hypertension may be reasonably stable on appropriate medication, but have intellectual deficiencies preventing safe use of self-medication, or other problems requiring frequent nursing appraisal, and thus be considered to meet low-intensity patient status; or
3. An individual with a stable medical condition manifesting a significant combination of at least two (2) or more of the following care needs shall be determined to meet low-intensity patient status:
 - a. Assistance with personal care;
 - b. Medication administration via a medication planner filled by a registered nurse or licensed practical nurse;
 - c. Assistance with transferring to or propelling a wheelchair;
 - d. Physical or environmental management for confusion and mild agitation;
 - e. Must have assistance and be present during the entire meal time;
 - f. Physical assistance with going to the bathroom or using a bedpan for elimination;
 - g. Existing colostomy care;
 - h. ~~In-dwelling~~ ~~[Indwelling]~~ catheter for dry care;
 - i. Changes in bed position;
 - j. Administration of stabilized dosages of medication;
 - k. Restorative and supportive nursing care to maintain the individual and prevent deterioration of the individual's condition;
 - l. Administration of injections during time licensed personnel is available; or
 - m. Routine administration of oxygen after a regimen of therapy has been established.

(b) An individual shall not be considered to meet low-intensity patient status criteria if care needs are limited to the following:

1. Verbal or gestural assistance with activities of daily living;
2. Independent use of mechanical devices, for example, assistance in mobility by means of a wheelchair, walker, crutch, or cane;
3. A limited diet, such as low salt, low residue, reducing, or another minor restrictive diet; or
4. Medications that can be self-administered or the individual requires minimal assistance, such as set up of medications or simple cuing.

(4) An individual who meets patient status criteria shall be specifically excluded from coverage if the department determines that in the individual case the combination of care needs are beyond the capability of the facility and that placement in the facility is inappropriate due to potential danger to the health and welfare of the individual, other patients in the facility, or staff of the facility.

(5) An individual shall be considered to meet the level of care criteria for ICF-IID if the individual meets criteria for a diagnosis of an intellectual disability as defined by the current Diagnostic and Statistical Manual of Mental ~~Disorders~~~~[Diseases]~~ (DSM) with onset of condition prior to age eighteen (18) or meets criteria for a person with a related

condition as defined by 42 C.F.R. 435.1010 with onset of condition prior to age twenty-two (22) and meets the following criteria:

- (a) Requires physical or environmental management or habilitation;
 - (b) Requires a planned program of active treatment;
 - (c) Requires a protected environment; and
 - (d) Unrelated to age appropriate dependencies with respect to a minor, has substantial deficits in adaptive functioning that, without ongoing support, limit functioning in one (1) or more activities of daily living (ADLs), ~~[life]~~ such as communication, social participation, and independent living across multiple environments, such as home, school, work, and community.
- (6) An individual who does not require a planned program of active treatment to attain or maintain the individual's optimal level of functioning shall not meet ICF-IID patient status.
- (7) An individual shall not be denied for ICF-IID services solely due to advanced age, length of stay in an institution, or history of previous institutionalization, if the individual qualifies for ICF-IID services on the basis of all other factors.
- (8) Transfer trauma criteria. A Medicaid recipient in an NF who does not meet the low-intensity or high-intensity nursing care patient status criteria established in this section shall not be discharged from an NF if:
- (a) The recipient has resided in an NF for at least eighteen (18) consecutive months;
 - (b) The recipient's attending physician determines that the recipient would suffer transfer trauma in that the individual's physical, emotional, or mental well-being would be compromised by a discharge action as a result of not meeting patient status criteria; and
 - (c) The department confirms the recipient's attending physician's assessment regarding the trauma caused by possible discharge from the NF.
- (9) A Medicaid recipient who meets transfer trauma criteria in accordance with subsection (8) of this section shall:
- (a) Remain in an NF and continue to be covered by the department for provider reimbursement at least until the individual's subsequent transfer trauma assessment; and
 - (b) Be reassessed for transfer trauma every 180 calendar days.
- (10) The recipient transfer trauma criteria established in subsection (8) of this section shall not apply to an individual who resides in a facility that experiences closure or a license or certificate revocation.

Section 5. Reevaluation of Need for Service.

- (1) Nursing facility, nursing facility with Medicaid waiver, or ICF-IID services shall continue to be provided to an individual if the individual's health status and care needs are within the scope of program benefits as described in Sections 3 and 4 of this administrative regulation.
- (2) An individual's patient status shall be reevaluated at least once every twelve (12) months.
- (3) Except as provided in Section 4(8) and (9) of this administrative regulation, if a reevaluation of care needs reveals that an individual no longer requires high-intensity nursing care, low-intensity nursing care, or intermediate care for an individual with an intellectual or a developmental disability:
 - (a) Payment shall continue for ten (10) calendar days to permit orderly discharge or transfer to an appropriate level of care; and
 - (b) Ten (10) calendar days from the date the reevaluation is finalized, payment shall no longer be appropriate to the facility.

Section 6. Requirements, Standards, and Preauthorization of Specialized Rehabilitation Services for Individuals with Brain Injuries. An individual who has a brain injury and meets the high-intensity nursing care patient status criteria established in Section 4 of this administrative regulation or is qualified under subsection (5) of this section shall be provided care in a certified unit providing specialized rehabilitation services for persons with brain injuries (i.e., brain injury unit) if the care is preauthorized by the department using criteria specified in this section. For coverage to occur, authorization of coverage shall be granted prior to admission of the individual with the brain injury into the certified brain injury unit, or if previously admitted to the unit with other third party coverage, authorization shall be granted prior to exhaustion of those benefits.

- (1) Injuries within the scope of benefits shall be:
 - (a) Central nervous system injury from physical trauma;
 - (b) Central nervous system damage from anoxia or hypoxic episodes; or
 - (c) Central nervous system damage from an allergic condition, toxic substance, or another acute medical or clinical incident.
- (2) The following items shall be indicators for admission and continued stay:
 - (a) The individual sustained a traumatic brain injury with structural, nondegenerative brain damage and is medically stable;
 - (b) The individual shall not be in a persistent vegetative state;
 - (c) The individual demonstrates physical, behavioral, and cognitive rehabilitation potential;
 - (d) The individual requires coma management; or
 - (e) The individual has sustained diffuse brain damage caused by anoxia, toxic poisoning, or encephalitis.
- (3) The determination as to whether preauthorization is appropriate shall be made taking into consideration the following:
 - (a) The presenting problem;
 - (b) The goals and expected benefits of the admission;
 - (c) The initial estimated time frames for goal accomplishment; and
 - (d) The services needed.
- (4) The following list of conditions shall not be considered brain injuries requiring specialized rehabilitation under this section:
 - (a) A stroke treatable in a nursing facility providing routine rehabilitation services;
 - (b) A spinal cord injury in which there is no known or obvious injury to the intracranial central nervous system;
 - (c) Progressive dementia or other mentally impairing condition;
 - (d) Depression or psychiatric disorder in which there is no known or obvious central nervous system damage;
 - (e) An intellectual disability or birth defect related disorder of long standing; or
 - (f) Neurological degenerative, metabolic, or other medical condition of a chronic, degenerative nature.
- (5) An individual may qualify for coverage under the brain injury program if:
 - (a) The individual has a stable medical condition with complicating care needs that prevent the individual from caring for himself or herself in an ordinary manner outside an institution;
 - (b) The individual has sufficient neurobehavioral sequelae resulting from the brain injury that, when taken in combination, require specialized rehabilitation services; and
 - (c) The following criteria are met:
 1. The individual shall not have previously received specialized rehabilitation services (an individual discharged for the purpose of transfer to another brain injury facility shall not be considered to have "previously received specialized rehabilitation services") as established in this section;

2. The individual shall have the potential for rehabilitation;
3. The care shall be prior authorized on an individual basis by the department; and
4. No more than 180 calendar days shall be approved per authorization.

Section 7. Requirements, Standards, and Preauthorization of Certified Distinct-part Nursing Facility Ventilator Services. An individual who is ventilator dependent and meets the high-intensity nursing care patient status criteria established in Section 4(2) of this administrative regulation shall be provided care in a certified distinct-part ventilator nursing facility unit providing specialized ventilator services if the care is preauthorized using criteria specified in this section.

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

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

(b) A certified distinct-part nursing facility unit shall:

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

(2) This subsection shall constitute the patient criteria and treatment characteristics for a distinct-part ventilator nursing facility.

(a) An individual shall be considered ventilator dependent if the individual:

1. Requires:

- a. This mechanical support for twelve (12) or more hours per day; and
 - b. Twenty-four (24) hours per day high-intensity nursing care services; or
2. Is in an active weaning program ordered by and under the management of a physician and reviewed and approved by the department; and
- a. The goal of the active weaning program is to attain the least mechanical support in the least invasive manner that is consistent with the maximal function of the individual and ultimately no mechanical respiratory support;
 - b. The individual demonstrates steady progress in decreasing the number of hours and dependence upon the ventilator as documented in the individual's physician and nursing progress notes; and
 - c. The individual requires twenty-four (24) hours per day high-intensity nursing care services.

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

1. The individual is no longer demonstrating steady progress in decreasing the number of hours and dependence upon the ventilator; or
2. The individual has been off the ventilator for seventy-two (72) consecutive hours.

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

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

(3) A patient status determination shall be made taking into consideration the following factors:

- (a) Alternative care possibilities;
- (b) Goals for patient care;
- (c) Primary hypoventilation, restrictive lung, ventilatory muscular dysfunction, or obstructive airway disorders needs that may necessitate mechanical ventilator and related care;
- (d) Patient treatment characteristics;
- (e) Home care potential;
- (f) Suitability of transfer to the ventilator care unit; and
- (g) Provision of an appropriate place of care.

Section 8. Denial of Patient Status. If an individual does not meet Medicaid criteria for admission or continued stay in a nursing facility, nursing facility with Medicaid waiver, or ICF-IID, the individual may appeal the denial in accordance with 907 KAR 1:563.

Section 9. Reserved Bed Days. The department shall cover and reimburse for reserved bed days as established in this section.

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

- (a) Covered for a maximum of thirty (30) ~~fourteen (14)~~ days per calendar year due to hospitalization. Accumulated bed reserve days shall follow a resident if the resident relocates to another facility within a calendar year rather than starting over at zero due to the relocation;
- (b) Covered for a maximum of ten (10) days per calendar year for leaves of absence other than hospitalization. Accumulated bed reserve days shall follow a resident if the resident relocates to another facility within a calendar year rather than starting over at zero due to the relocation; and
- (c) Reimbursed at seventy-five (75) percent of a facility's rate ~~[if the facility's occupancy percentage is ninety-five (95) percent or greater; and]~~
- ~~[(d)] [Reimbursed at fifty (50) percent of a facility's rate if the facility's occupancy percentage is less than ninety-five (95) percent].~~

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

- (a) Reserved bed days, per resident, for an ICF-IID shall:
 - 1. Be covered for a maximum of forty-five (45) days within a calendar quarter; and
 - 2. Not exceed fifteen (15) calendar days per stay due to hospitalization; and
- (b) More than thirty (30) consecutive reserved bed days due to hospitalization plus leave of absence or due to leave of absence shall not be approved for coverage.

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

- (a) The individual shall:
 - 1. Be in Medicaid payment status in the level of care the individual is authorized to receive; and
 - 2. Have been a resident of the facility at least overnight;
- (b) An individual for whom Medicaid is making Medicare coinsurance payments shall not be considered to be in Medicaid payment status for purposes of this policy;
- (c) The individual shall be reasonably expected to return to the same level of care;
- (d) Due to demand at the facility for beds at that level, there shall be a likelihood that the bed would be occupied by another patient were it not reserved;
- (e) The hospitalization shall be for treatment of an acute condition, and not for testing, brace-fitting, or another noncovered service;
- (f) For a leave of absence other than for hospitalization, the individual's plan of care shall include a physician's order providing for leave; and
- (g) A leave of absence shall include a visit with a relative or friend, or a leave to participate in a state-approved therapeutic or rehabilitative program.

- (4) Bed reservation days shall not be available for an individual admitted to a psychiatric hospital or ICF-IID.
- (5) An NF shall advise a resident prior to the resident's departure from the facility if the NF chooses not to reserve a bed for the resident.

Section 10. Determination of Patient Care Status.

- (1) ~~[(Prior to or on the date of)]~~
- (a) Upon admission of an individual, an NF shall complete a level of care application in a department approved system, which consists of a:
1. ~~[(a)]~~ Level I PASRR in accordance with 907 KAR 1:755, Section 4; and
 2. ~~[(b)]~~ A level of care request for admission in a department approved system, except for an individual requesting institutionalized hospice.
- (b) To comply with paragraph (a)1. of this subsection, the department may designate another entity to complete a PASRR level 1 review on behalf of a recipient.
- (2) Compliance with 907 KAR 1:755 shall be required in order for an individual to be admitted to an NF.
- (3)
- (a) The department shall:
1. Approve the level of care application;
 2. Deny the level of care application; or
 3. Request more information from the facility if all required information was not previously provided.
- (b) Notification of denial shall be sent to the:
1. Patient or their responsible party; and
 2. NF.
- (c) If the admission is approved, the department shall:
1. Except as provided by paragraph (d) of this subsection, perform a ~~an on-site~~ continuing stay review within ninety (90) ~~thirty (30)~~ calendar days of the admission to ensure the resident continues to meet the nursing facility level of care criteria in accordance with this administrative regulation; and
 2. Re-certify the resident once every twelve (12) months ~~180 calendar days~~.
- (d) There shall not be a review pursuant to paragraph (c)1. of this subsection for an individual who has a Level II PASRR.
- (4) Upon ~~[(Prior to or on the date of)]~~ admission of an individual to an ICF-IID, the facility shall complete a level of care request for admission in a department approved system.

907 KAR 1:022

LISA D. LEE, Commissioner

STEVEN J. STACK, MD, MBA, Secretary

APPROVED BY AGENCY: September 1, 2026

FILED WITH LRC: September 2, 2026 at 3:30 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on November 23, 2026, at 9:00 a.m., Eastern Time/8:00 a.m. Central Time, using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by November 16, 2026, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who attends virtually will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a

written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on this proposed administrative regulation through November 30, 2026. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; Phone: 502-564-7476; Fax: 502-564-7091; CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Krista Quarles/ Jonathan Scott **Phone Number:** (502) 564-7476/ (502) 564-4321 **Email:** CHFSregs@ky.gov/ Jonathant.scott@ky.gov

Subject Headings:Medicaid, Nursing Facilities, Health and Medical Services, Disability and Disabilities

(1) Provide a brief summary of:

(a) What this administrative regulation does:

This administrative regulation establishes the provisions relating to nursing facility services and services at an intermediate care facility for individuals with an intellectual disability 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 to establish the provisions relating to nursing facility services and services at an intermediate care facility for individuals with an intellectual disability 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 the authorizing statutes by establishing the provisions relating to nursing facility services and services at an intermediate care facility for individuals with an intellectual disability 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 will assist in the effective administration of the authorizing statutes by establishing the provisions relating to nursing facility services and services at an intermediate care facility for individuals with an intellectual disability 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 amendments to this administrative regulation increase the number of reimbursable bed days for nursing facilities and removes the occupancy requirement related to the reimbursement rate to provide a standardized reimbursement rate of 75%. A once per six (6) month recertification has been increased to twelve (12) months to make all processes within the regulation – especially those in Sections 5 and 10 of the regulation - internally consistent to a twelve (12) month review process.

(b) The necessity of the amendment to this administrative regulation:

The amendment serves to increase the number of reimbursable bed days for nursing facilities, standardize the reimbursement rate for nursing facilities, and provide additional time for the completion of a resident's continuing stay review.

(c) How the amendment conforms to the content of the authorizing statutes:

The amendment conforms to the content of the authorizing statutes by establishing clear requirements for level of care procedures for nursing facilities.

(d) How the amendment will assist in the effective administration of the statutes:

The amendment will assist in the effective administration of the authorizing statutes by updating nursing facility level of care requirements.

(3) Does this administrative regulation or amendment implement legislation from the previous five years?No

(4) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:

There are approximately 286 nursing facilities in Kentucky who may be affected by this administrative regulation.

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

(a) List the actions that each of the regulated entities identified in question (4) will have to take to comply with this administrative regulation or amendment:

Nursing facilities will need to update their procedures to receive reimbursement for the increase in bed days at the appropriate rate.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (4):

There is no cost to the entity.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (4):

Nursing facilities will be eligible for an increased number of reimbursable days, and some nursing facilities will be eligible for an increased reimbursement rate based on their occupancy level.

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

(a) Initially:

DMS anticipates that the expenditures for nursing facilities will be consistent with appropriations in 2026 Ky. Acts Chapter 168.

(b) On a continuing basis:

DMS anticipates that the expenditures for nursing facilities will be consistent with appropriations in 2026 Ky. Acts Chapter 168.

(7) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation or this amendment:

Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(8) 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:

At this time, DMS does not assess that an increase in fees or funding is necessary to implement this administrative regulation.

(9) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees:

This administrative regulation neither establishes nor increases any fees.

(10) TIERING: Is tiering applied?

Tiering is not applied as the policies apply equally to the regulated entities.

FISCAL IMPACT STATEMENT

(1) Identify each state statute, federal statute, or federal regulation that requires or authorizes the action taken by the administrative regulation.

42 C.F.R. 431.153, 431.154, 447.280, 482.58, 42 U.S.C. 1395tt, 1396l, 1396r; KRS 194A.030(2), 194A.050(1), 205.520(3), 205.558

(2) Identify the promulgating agency and any other affected state units, parts, or divisions:

Cabinet for Health and Family Services, Department for Medicaid Services

(a) Estimate the following for the first year:

Expenditures:DMS does not anticipate additional costs as a result of this amendment.

Revenues:This administrative regulation is not expected to generate revenue to DMS.

Cost Savings:There are no expected cost savings to DMS.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

DMS does not anticipate additional costs as a result of this amendment.

(3) Identify affected local entities (for example: cities, counties, fire departments, school districts):

No local entities identified.

(a) Estimate the following for the first year:

Expenditures:N/A

Revenues:N/A

Cost Savings:N/A

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

N/A

(4) Identify additional regulated entities not listed in questions (2) or (3):

N/A

(a) Estimate the following for the first year:

Expenditures:N/A

Revenues:N/A

Cost Savings:N/A

(b) How will expenditures, revenues, or cost savings differ in subsequent years?

N/A

(5) Provide a narrative to explain the:

(a) Fiscal impact of this administrative regulation:

The amendment does not have an impact because availability of a sufficient number of intermediate care beds is necessary to ensure a proper level of care is provided to more vulnerable Medicaid recipients.

(b) Methodology and resources used to determine the fiscal impact:

The department has worked with an outside consultant to ensure that this step stabilizes the availability of intermediate care facility beds for the anticipated Medicaid population.

(6) Explain:

(a) Whether this administrative regulation will have an overall negative or adverse major economic impact to the entities identified in questions (2) - (4). (\$500,000 or more, in aggregate)

This administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities.

(b) The methodology and resources used to reach this conclusion:

The department has worked with an outside consultant to ensure that this step stabilizes the availability of intermediate care facility beds for the anticipated Medicaid population.

FEDERAL MANDATE ANALYSIS COMPARISON

(1) Federal statute or regulation constituting the federal mandate.

42 C.F.R. 431.153, 431.154, 447.280, 482.58, 42 U.S.C. 1395tt, 1396l, 1396r

(2) State compliance standards.

KRS 205.520(3), KRS 194A.030(2), 194A.050(1), 205.520(3), 205.558

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

42 U.S.C. 1396R establishes requirements for nursing facilities.

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

The administrative regulation does not impose stricter than federal requirements.

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

The administrative regulation does not impose stricter than federal requirements.