CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Fiscal Management
(Amendment)

907 KAR 1:595. Model Waiver II service coverage and reimbursement policies and requirements.

RELATES TO: KRS 205.8451(9), 314.011, 314A.010(3)(a), 42 C.F.R. 400.203, 42 C.F.R. 440.70, 440.185, 42 U.S.C. 1396, 42 U.S.C. 1396n(c)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1315

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, to qualify for federal Medicaid funds. This administrative regulation establishes the service coverage and reimbursement policies and requirements relating to Model Waiver II services provided to a Medicaid-eligible recipient. These services are provided pursuant to a 1915(c) home and community based waiver granted by the U. S. Department for Health and Human Services in accordance with 42 U.S.C. 1396n(c).

Section 1. Definitions.

(1) "1915(c) home and community based waiver program" means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).
(2) "Department" means the Department for Medicaid Services or its designee.
(3) "Federal financial participation" is defined in 42 C.F.R. 400.203.
(4) "Home health agency" means an agency that is:
(a) Licensed in accordance with 902 KAR 20:081;
(b) Medicare certified; and
(c) Medicaid certified.
(5) "Licensed practical nurse (LPN)" is defined by KRS 314.011(9).
(6) "Model Waiver II services" means 1915(c) home and community based waiver program in-home ventilator services provided to a Medicaid-eligible recipient who:
(a) Is dependent on a ventilator; and
(b) Would otherwise require a nursing facility level of care in a hospital based nursing facility that will accept a recipient who is dependent on a ventilator.
(7) "MWMA" means the Kentucky Medicaid Waiver Management Application internet portal located at https://www.chfs.ky.gov/agencies/dms/dca/Pages/mwma.aspx[~~http://chfs.ky.gov/dms/mwma.htm~~].
(8) "Participant" means a recipient who qualifies for and is receiving Model Waiver II services in accordance with Section 2 of this administrative regulation.
(9) "Person-centered service plan" means a written individualized plan of services.
(10) "Private duty nursing agency" means a facility licensed to provide private duty nursing services:
(a) By the Cabinet for Health and Family Services, Office of Inspector General; and
(b) Pursuant to 902 KAR 20:370.
(11) "Recipient" is defined by KRS 205.8451(9).
(12) "Registered nurse (RN)" is defined by KRS 314.011(5).
(13) "Registered respiratory therapist (RT)" is defined by KRS 314A.010(3)(a).
(14) "Ventilator" means a respiration stimulating mechanism.
(15) "Ventilator dependent" means the condition or state of an individual who:
(a) Requires the aid of a ventilator for respiratory function; and
(b) Meets the high intensity nursing facility patient status criteria established in 907 KAR 1:022.

Section 2. Participant Eligibility and Related Policies.

(1)
(a) To be eligible to receive Model Waiver II services, an individual shall:
1. Be eligible for Medicaid pursuant to 907 KAR 20:010;
2. Require ventilator support for at least twelve (12) hours per day; and
3. Meet ventilator dependent patient status requirements established in 907 KAR 1:022.
(b) In addition to the individual meeting the requirements established in paragraph (a) of this subsection:
1. The individual or a representative on behalf of the individual shall:
a. Apply for 1915(c) home and community based waiver services via the MWMA;
b. Complete and upload into the MWMA a MAP - 115 Application Intake - Participant Authorization; and
c. Complete and upload into the MWMA a MAP - 116 Service Plan – Participant Authorization prior to or at the time the person-centered service plan is uploaded into the MWMA; and
2. A registered nurse on behalf of the individual applying for services shall:

a. Complete and upload into the MWMA:

(i) A MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form;

(ii) A person-centered service plan; and

(iii) A MAP-351A, Medicaid Waiver Assessment; and

b. Upload a MAP-10, Waiver Services – Physician's Recommendation, which shall be signed and dated by a physician.

(c) An individual's eligibility for Model Waiver II services shall begin upon receiving notification of approval from the department.

(2) For an individual to remain eligible for Model Waiver II services:

(a) The individual shall:

1. Maintain Medicaid eligibility requirements established in 907 KAR 20:010; and

2. Remain ventilator dependent pursuant to 907 KAR 1:022;

(b) A Model Waiver II level of care determination confirming that the individual qualifies shall be performed and submitted to the department every six (6) months; and

(c) A MAP-10[,] Waiver Services – Physician's Recommendation shall be:

1. Signed and dated by a physician every sixty (60) days on behalf of the individual; and

2. Uploaded into the MWMA after being signed and dated in accordance with subparagraph 1 of this paragraph, every sixty (60) days.

(3) A Model Waiver II service shall not be provided to a recipient who is:

(a) Receiving a service in another 1915(c) home and community based waiver program; or

(b) An inpatient of:

1. A nursing facility;

2. An intermediate care facility for individuals with an intellectual disability; or

3. Another facility.

(4) The department shall not authorize a Model Waiver II service unless it has ensured that:

(a) Ventilator dependent status has been met; and

(b) The service:

1. Is available to the recipient;

2. Will meet the need of the recipient; and

3. Does not exceed the cost of traditional institutional ventilator care.

Section 3. Provider Participation Requirements. To participate in the Model Waiver II program, a:

(1) Home health agency shall:

(a) Be a currently participating Medicaid provider in accordance with 907 KAR 1:671;

(b) Be currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and

(c) Meet the home and community based waiver service provider requirements established in:

1. 907 KAR 1:160; or

2. 907 KAR 7:010; or

(2) Private duty nursing agency shall:

(a) Be a currently participating Medicaid provider in accordance with 907 KAR 1:671;

(b) Be currently enrolled as a Medicaid provider in accordance with 907 KAR 1:672; and

(c) Be a licensed private duty nursing agency in accordance with 902 KAR 20:370.

Section 4. Covered Services.

(1) The following shall be covered Model Waiver II services:

(a) Skilled nursing provided by:

1. A registered nurse; or

2. A licensed practical nurse; or

(b) Respiratory therapy.

(2) Model Waiver II services shall be provided by an individual employed by or under contract through a private duty nursing agency or home health agency as a:

(a) Registered nurse;

(b) Licensed practical nurse; or

(c) Registered respiratory therapist.

Section 5. Payment for Services. The department shall reimburse a participating home health agency or private duty nursing agency for the provision of covered Model Waiver II services as established in this section.

(1) Reimbursement shall be as established by the following table:

Service	Unit	Base Rate Effective January 1, 2025
Skilled Services by an LPN	15-minutes	$11.58
Skilled Services by an RN	15-minutes	$15.99
Skilled Services by an RN or LPN	15-minutes	$15.99

Skilled Services by an RT 15-minutes $13.36

(2) [based on a fixed fee for a unit of service provided for each covered service referenced in Section 4 of this administrative regulation with one (1) hour equal to one (1) unit of service.]
[(2)] [The fixed fee for skilled nursing services provided by:]
[(a)] [A registered nurse shall be thirty-one (31) dollars and ninety-eight (98) cents for each unit of service;]
[(b)] [A licensed practical nurse shall be twenty-nine (29) dollars and ten (10) cents for each unit of service; and]
[(c)] [A registered respiratory therapist shall be twenty-seven (27) dollars and forty-two (42) cents for each unit of service.]
[(3)] [Reimbursement shall not exceed sixteen (16) units of service per day.]
[(4)] Payment shall not be made for a service to an individual for whom it can reasonably be expected that the cost of the 1915(c) home and community based waiver program service furnished under this administrative regulation would exceed the cost of the service if provided in a hospital-based nursing facility.

Section 6. Maintenance of Records.
(1) A Model Waiver II service provider shall maintain:
(a) A clinical record for each participant, which shall contain:
1. Pertinent medical, nursing, and social history;
2. A person-centered service plan;
3. A copy of the MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form, signed by the participant or the participant's legal representative at the time of application or reapplication and each recertification thereafter;
4. Documentation of all level of care determinations;
5. All documentation related to prior authorizations including requests, approvals, and denials;
6. Documentation that the participant or legal representative was informed of the procedure for reporting complaints; and
7. Documentation of each service provided that shall include:
a. The date the service was provided;
b. The duration of the service;
c. The arrival and departure time of the provider, excluding travel time, if the service was provided at the participant's home;
d. Progress notes, which shall include documentation of changes, responses, and treatments utilized to evaluate the participant's needs; and
e. The signature of the service provider;
(b) Each MAP-10[,] Waiver Services – Physician's Recommendation submitted regarding the participant in accordance with Section 2 of this administrative regulation; and
(c) Incident reports as required by Section 7 of this administrative regulation if an incident with the participant occurs.
(2)
(a) Except as provided in paragraph (b) of this subsection, a clinical record or incident report shall be retained for at least six (6) years from the date that a covered service is provided.
(b) If the participant is a minor, a clinical record or incident report shall be retained for three (3) years after the participant reaches the age of majority under state law, if that is a longer time period than the time period required by paragraph (a) of this subsection.
(3) Upon request, a provider shall make information regarding service and financial records available to the:
(a) Department;
(b) Cabinet for Health and Family Services, Office of Inspector General or its designee;
(c) United States Department for Health and Human Services or its designee;
(d) General Accounting Office or its designee;
(e) Office of the Auditor of Public Accounts or its designee; or
(f) Office of the Attorney General or its designee.

Section 7. Incident Reporting.
(1)
(a) There shall be two (2) classes of incidents.
(b) The following shall be the two (2) classes of incidents:
1. An incident; or
2. A critical incident.
(2) An incident shall be any occurrence that impacts the health, safety, welfare, or lifestyle choice of a participant and includes:
(a) A minor injury;
(b) A medication error without a serious outcome; or
(c) A behavior or situation that is not a critical incident.

(3) A critical incident shall be an alleged, suspected, or actual occurrence of an incident that:
(a) Can reasonably be expected to result in harm to a participant; and
(b) Shall include:
1. Abuse, neglect, or exploitation;
2. A serious medication error;
3. Death;
4. A homicidal or suicidal ideation;
5. A missing person; or
6. Other action or event that the provider determines may result in harm to the participant.
(4)
(a) If an incident occurs, the Model Waiver II provider shall:
1. Report the incident by making an entry into the MWMA that includes details regarding the incident; and
2. Be immediately assessed for potential abuse, neglect, or exploitation.
(b) If an assessment of an incident indicates that the potential for abuse, neglect, or exploitation exists:
1. The incident shall immediately be considered a critical incident;
2. The critical incident procedures established in subsection (5) of this section shall be followed; and
3. The Model Waiver II provider shall report the incident to the participant's registered nurse and participant's guardian, if the participant has a guardian, within twenty-four (24) hours of discovery of the incident.
(5) If a critical incident occurs, the:
(a) Individual who witnessed the critical incident or discovered the critical incident shall immediately:
1. Act to ensure the health, safety, and welfare of the at-risk participant; and
2. Report the critical incident by making an entry in the MWMA portal including details of the incident; and
(b) Model Waiver II provider shall:
1. Conduct an immediate investigation and involve the participant's registered nurse in the investigation; and
2. Prepare a report of the investigation, which shall be recorded in the MWMA portal and shall include:
a. Identifying information of the participant involved in the critical incident and the person reporting the critical incident;
b. Details of the critical incident; and
c. Relevant participant information including:
(i) A listing of recent medical concerns;
(ii) An analysis of causal factors; and
(iii) Recommendations for preventing future occurrences.
(6) If a critical incident does not require reporting of abuse, neglect, or exploitation, the critical incident shall be reported via the MWMA within eight (8) hours of discovery.
(7) If a death of a participant occurs, a Model Waiver II provider shall submit to the MWMA mortality data documentation within fourteen (14) days of the death including:
(a) The participant's person-centered service plan at the time of death;
(b) Any current assessment forms regarding the participant;
(c) The participant's medication administration records from all service sites for the past three (3) months along with a copy of each prescription;
(d) Progress notes regarding the participant from all service elements for the past thirty (30) days;
(e) The results of the participant's most recent physical exam;
(f) All incident reports, if any exist, regarding the participant for the past six (6) months;
(g) Any medication error report, if any exists, related to the participant for the past six (6) months;
(h) A full life history of the participant including any update from the last version of the life history;
(i) Names and contact information for all staff members who provided direct care to the participant during the last thirty (30) days of the participant's life;
(j) Emergency medical services notes regarding the participant if available;
(k) The police report if available;
(l) A copy of:
1. The participant's advance directive, medical order for scope of treatment, living will, or health care directive if applicable; and
2. The cardiopulmonary resuscitation and first aid card for any provider's staff member who was present at the time of the incident that resulted in the participant's death;
(m) A record of all medical appointments or emergency room visits by the participant within the past twelve (12) months; and
(n) A record of any crisis training for any staff member present at the time of the incident that resulted in the participant's death.
(8) A Model Waiver II provider shall report a medication error by making an entry into the MWMA.

Section 8. Use of Electronic Signatures. The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

Section 9. Federal Financial Participation. The department's coverage of and reimbursement for Model Waiver II services pursuant to this administrative regulation shall be contingent upon:

(1) Federal financial participation for the coverage and reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage and reimbursement.

Section 10. Appeal Rights.

(1) An appeal of a negative action regarding a Medicaid recipient shall be appealed in accordance with 907 KAR 1:563.

(2) An appeal of a negative action regarding a Medicaid beneficiary's eligibility shall be appealed in accordance with 907 KAR 1:560.

(3) An appeal of a negative action regarding a Medicaid provider shall be appealed in accordance with 907 KAR 1:671.

Section 11. Incorporation by Reference.

(1) The following material is incorporated by reference:

(a) "MAP - 115 Application Intake - Participant Authorization", June 2015;

(b) "MAP 350, Long Term Care Facilities and Home and Community Based Program Certification Form", June 2015;

(c) "MAP-10 Waiver Services – Physician's Recommendation", June 2015;

(d) "MAP - 116 Service Plan – Participant Authorization", June 2015; and

(e) MAP-351A, Medicaid Waiver Assessment", July 2015.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law:

(a) At the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Online at the department's Web site at https://www.chfs.ky.gov/agencies/dms/dca/Pages/mIIws.aspx[~~http://www.chfs.ky.gov/dms/incorporated.htm~~].

(907 KAR 001:595. 24 Ky.R. 2788, 25 Ky.R. 585, 863; eff. 9-16-1998; 38 Ky.R. 697, 968; eff. 12-2-11; 39 Ky.R. 2438; eff. 9-6-2013; TAm 9-30-2013; 42 Ky.R. 968, 2150; eff. 2-5-2016; Cert eff. 1-30-2023; 51 Ky.R. 1558; eff. 7-30-2025.)

LISA D. LEE, Commissioner
ERIC C. FRIEDLANDER, Secretary

APPROVED BY AGENCY: December 20, 2024

FILED WITH LRC: December 23, 2024

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on March 24, 2025, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by March 17, 2025, 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 until March 31, 2025. 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; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Jonathan Scott or Krista Quarles

(1) Provide a brief summary of:

(a) What this administrative regulation does:
This administrative regulation establishes the service coverage and reimbursement policies for the Medicaid Model Waiver II services. This program enables individuals who have nursing facility level of care needs primarily due to needing to be on a ventilator for at least twelve (12) hours per day to be able to receive services in the home rather than being admitted to a nursing facility.

(b) The necessity of this administrative regulation:
This administrative regulation is necessary to establish the service coverage and reimbursement policies for the Medicaid Model Waiver II services.

(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 service coverage and reimbursement policies for the Medicaid Model Waiver II services.

(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 the statutes by establishing the service coverage and reimbursement policies for the Medicaid Model Waiver II services.

(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 delete and update the reimbursement methodology to reflect the approval of new federal 1915(c) waivers. The approvals allow for higher reimbursement for providers, and this administrative regulation is being updated to reflect the higher reimbursement. Other amendments were made to conform to KRS 13A drafting requirements.

(b) The necessity of the amendment to this administrative regulation:
This amendment is necessary to update reimbursement methodology to new, higher rates approved by the federal government.

(c) How the amendment conforms to the content of the authorizing statutes:
This amendment conforms to the content of the authorizing statutes by implementing a federally approved rate increase.

(d) How the amendment will assist in the effective administration of the statutes:
This amendment assists with the affective administration of the statutes by establishing a process to update increased federal reimbursement.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:
DMS anticipates that up to 100 recipients will utilize the services available under this waiver.

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

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment:
No action is required, regulated entities will be able to bill and receive a higher reimbursement.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3):
Regulated entities will experience no new costs in complying with this administrative regulation.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3):
Recipients will be able to participate in the expanded reimbursement available for this waiver.

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

(a) Initially:
DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

(b) On a continuing basis:
DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

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

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.

(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:

Neither an increase in fees nor funding will be necessary to implement the amendments.

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

The amendment does not establish or increase any fees.

(9) TIERING: Is tiering applied?

Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL IMPACT STATEMENT

(1) Identify each state statute, federal statute, or federal regulation that requires or authorizes the action taken by the administrative regulation.
KRS 194A.030(2), 194A.050(1), 205.520(3).

(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 anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

Revenues:The department does not anticipate revenues as a result of this administrative regulation.

Cost Savings:The department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?
DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

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

(a) Estimate the following for the first year:

Expenditures:DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6.

Revenues:The department does not anticipate revenues as a result of this administrative regulation.

Cost Savings:The department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?
DMS does not expect additional expenditures, revenues, or cost savings for local entities as a result of this regulation.

(4) Identify additional regulated entities not listed in questions (2) or (3):
Enrolled providers providing Model Waiver II services.

(a) Estimate the following for the first year:

Expenditures:DMS does not anticipate additional expenditures for regulated entities.

Revenues:Participating providers will benefit from increased reimbursement.

Cost Savings:The department does not anticipate cost savings as a result of this administrative regulation.

(b) How will expenditures, revenues, or cost savings differ in subsequent years?
DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6. Future slots and increases will be dependent on the state budgeting process and federal reimbursement requirements.

(5) Provide a narrative to explain the:

(a) Fiscal impact of this administrative regulation:
DMS anticipates no additional costs beyond those budgeted in 2024 Regular Session HB 6. Future slots and increases will be dependent on the state budgeting process and federal reimbursement requirements.

(b) Methodology and resources used to determine the fiscal impact:
The department worked with interested parties to gain input and perspectives as well as completed a multiyear process working with a contracted third party to re-design the 1915(c) waivers and reimbursement.

(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)
The 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:
This administrative regulation will provide additional reimbursement for all 1915(c) providers.

FEDERAL MANDATE ANALYSIS COMPARISON

(1) Federal statute or regulation constituting the federal mandate.
42 C.F.R. 441.305(b).

(2) State compliance standards.
KRS 205.520(3) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

(3) Minimum or uniform standards contained in the federal mandate.
Federal approval is for a limited number of waiver slots.

(4) Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?
The amendment will not impose stricter than federal requirements.

(5) Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.
The amendment will not impose stricter than federal requirements.