STATEMENT OF EMERGENCY

907 KAR 3:100E

(1) This emergency administrative regulation is being promulgated to establish a residential care model which is tailored to recipients' needs as well as cost effective for the Medicaid program. This administrative regulation is being amended in conjunction with a companion acquired brain injury services regulation.

(2) This action must be implemented on an emergency basis to ensure the availability of funding necessary for the continued operation of the Medicaid program. Failure to enact this administrative regulation on an emergency basis would pose an imminent threat to the public health, safety or welfare of Medicaid recipients whose receipt of services may be jeopardized due to a lack of funding.

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

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

_____
Steven L. Beshear
Governor

_____
Janie Miller, Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Community Alternatives

(Emergency Amendment)

907 KAR 3:100E. Reimbursement for acquired brain injury waiver services[~~Payments for acquired brain injury services~~].

RELATES TO: 42 CFR 441.300 – 310,[~~42 CFR 441 Subpart G,~~] 42 USC 1396a, b, d, n

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(3), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health 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 for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the payment provisions relating to home- and community-based waiver services provided to an individual with an acquired brain injury as an alternative to nursing facility services for the purpose of rehabilitation and retraining for reentry into the community with existing resources.

Section 1. Definitions. (1) "ABI" means an acquired brain injury.

(2) "ABI provider" means an entity that meets the provider criteria established in Section 2 of 907 KAR 3:090.

(3) "ABI recipient" means an individual who meets the ABI recipient criteria established in Section 3 of 907 KAR 3:090.

(4) "Acquired brain injury waiver services" or "ABI waiver services" means home- and community-based waiver services provided to a Medicaid eligible individual aged twenty-one (21) to sixty-five (65) who has acquired a brain injury to his central nervous system of the following nature:

(a) Injury from a physical trauma;

(b) Damage from anoxia or from a hypoxic episode; or

(c) Damage from an allergic condition, toxic substance or another acute medical incident.

(5) "Consumer" is defined by KRS 205.5605(2).

(6) "Consumer directed option" or "CDO" means an option established by KRS 205.5606 within the home and community based services waiver that allows recipients to:

(a) Assist with the design of their programs;

(b) Choose their providers of services; and

(c) Direct the delivery of services to meet their needs.

(7)[~~(2)~~] "Department" means the Department for Medicaid Services or its designated agent.

(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

Section 2. Coverage. [~~(1)~~] The department shall reimburse a participating provider for:

(1) An ABI waiver service provided to a Medicaid eligible person who meets the ABI waiver program requirements as established in 907 KAR 3:090; and

(2) A prior authorized ABI waiver service, if the service is:

(a) Included in the recipient's plan of care;

(b) Medically necessary; and

(c) Essential for the rehabilitation and retraining of the recipient.[~~(2) The department shall reimburse an ABI participating provider for a prior-authorized ABI waiver service, if the service is:~~

~~(a) Included in the plan of care and Is medically necessary, as defined in 907 KAR 3:130; and~~

~~(b) Essential for the rehabilitation and retraining of the recipient.~~]

Section 3. Exclusions to Acquired Brain Injury Waiver Program. Under the ABI waiver program, the department shall not reimburse a provider for a service provided:

(1) To an individual who has a condition identified in 907 KAR 3:090, Section 5[~~2~~]; or

(2) Which has not been prior authorized as a part of the recipient's plan of care.

Section 4. Payment Amounts. (1) A participating ABI waiver service provider shall be reimbursed a fixed rate for reasonable and medically necessary services for a prior-authorized unit of service provided to a recipient.

(2) A participating ABI waiver service provider certified in accordance with 907 KAR 3:090 shall be reimbursed at the lesser of:

(a) The provider's usual and customary charge; or

(b) The Medicaid fixed upper payment limit per unit of service as established in Section 5 of this administrative regulation.

Section 5. Fixed Upper Payment Limits. (1) The following respective rates shall be the fixed upper payment limits[~~, in effect on July 1, 2001,~~] for the corresponding respective ABI waiver services in conjunction with the corresponding units of service and unit of service limits:

Service	Unit of Service	Unit of Service Limit	Upper Payment Limit
case management	1 month	1 unit per ABI recipient per month	$434.00 per month
personal care	15 minutes	80 units per week	$5.56 per unit
respite care	15 minutes	336 hours per 12-month period	$4.00 per unit
companion	15 minutes	200 units per week	$5.56 per unit
adult day training	15 minutes	160 units, alone or in combination with supported employment, per calendar week	$4.03 per unit
supported employment	15 minutes	160 units, alone or in combination	$7.98 per unit

		with adult day training, per calendar week	
behavior programming	15 minutes		$33.61
counseling - group	15 minutes	2 – 8 people in a group setting and 48 units per ABI recipient per calendar month	$5.75 per unit
counseling - individual	15 minutes	16 units per day	$23.84 per unit
occupational therapy	15 minutes	16 units per day	$25.90 per unit
speech, hearing and language services	15 minutes	16 units per day	$28.41 per unit
specialized medical equipment and supplies (see subsection (2) of this	per Item	as negotiated by the department	as negotiated by the department

section)			
environmental modification	per modification	actual cost not to exceed $2,000.00 per 12-month period	actual cost not to exceed $2,000.00 per 12-month period
supervised residential care level I	1 calendar day	1 unit per ABI recipient per calendar day	$200.00 per unit
supervised residential care level II	1 calendar day	1 unit per ABI recipient per calendar day	$150.00 per unit
supervised residential care level III	1 calendar day	1 unit per ABI recipient per calendar day	$75.00 per unit
assessment	the entire assessment equals 1 unit	1 unit per ABI recipient	$100.00 per unit
re-assessment	the entire reassessment equals 1 unit	1 unit per ABI recipient	$100.00 per unit
CDO home and community supports			service limited by prior authorized dollar amount based on the

			consumer's budget approved by the department
CDO community day supports			service limited by prior authorized dollar amount based on the consumer's budget approved by the department
CDO goods and services			service limited by prior authorized dollar amount based on the consumer's budget approved by the department
support broker	1 calendar month	1 unit per ABI recipient per calendar month	$375.00
financial management	15 minutes	8 units or $100.00 per month	$12.50 per unit

~~Service~~	~~Unit of Service~~	~~Upper Payment Limit~~
~~Case Management~~	~~1 month~~	~~$434.00~~

~~Personal Care~~	~~15 minutes~~	~~$5.56~~
~~Respite Care~~	~~1 hour (not to exceed 168 hours per six (6) month period)~~	~~$15.98 (maximum of $150.00 per day)~~
~~Companion~~	~~15 minutes~~	~~$5.56~~
~~Structured Day Program~~	~~1 hour (not to exceed forty (40) hours per week~~	~~$16.11~~
~~Supported Employment~~	~~1 hour~~	~~$31.92~~
~~Behavior Programming~~	~~15 minutes~~	~~$33.61~~
~~Counseling - Individual~~ ~~Counseling - Group~~	~~15 minutes~~ ~~15 minutes~~	~~$23.84~~ ~~$5.75~~
~~Occupational Therapy~~	~~15 minutes~~	~~$25.90~~
~~Service~~	~~Unit of Service~~	~~Upper Payment Limit~~
~~Speech, Hearing and Language Services~~	~~15 minutes~~	~~$28.41~~
~~Specialized Medical Equipment and Supplies (see subsection (2) of this section)~~	~~Per Item~~	~~As Negotiated by the Department~~
~~Environmental~~	~~Per Modification~~	~~Actual cost not to exceed~~

~~Modification~~		~~$1,000.00 per 6 month period~~
~~Community Residential Service (Staffed Residence)~~	~~Not Applicable~~	~~$200.00~~
~~Community Residential Service (Group Home)~~	~~Not Applicable~~	~~$90.00~~

(2) Specialized medical equipment and supplies shall be reimbursed on a per-item basis based on a reasonable cost as negotiated by the department if they meet the following criteria:

(a) The equipment or supply is:

1.[~~They are~~] not covered through the Medicaid durable medical equipment program established in 907 KAR 1:479; and

2.[~~(b) They are~~] Provided to an individual participating in the ABI waiver program.

(3) Respite care may exceed 336 hours in a twelve (12)[~~168 hours per six (6)~~] month period if an individual's normal care giver is unable to provide care due to a death in the family, serious illness, or hospitalization.

(4) [~~Payment for respite care provided in a setting other than a nursing facility shall not include the cost of room and board.~~]If an ABI recipient is placed in a nursing facility to receive respite care, the department shall pay the nursing facility its per diem rate for that individual.

(5) If supported employment services are provided at a work site in which persons without disabilities are employed, payment shall:

(a) Be made only for the supervision and training required as the result of the ABI recipient's disabilities; and

(b)[~~and shall~~] Not include payment for supervisory activities normally rendered.

(6)(a) The department shall only pay for supported employment services for an individual if supported employment services are unavailable under a program funded by either the Rehabilitation Act of 1973 (29 USC Chapter 16) or PL 94-142 (34 CFR Subtitle B, Chapter III).

(b) For an individual receiving supported employment services, documentation shall be maintained in his or her record demonstrating that the services are not otherwise available under a program funded by either the Rehabilitation Act of 1973 (29 USC Chapter 16) or PL 94-142 (34 CFR Subtitle B, Chapter III).

[~~(7) Except for state fiscal years (SFY) 2002 and 2003, The Medicaid fixed upper payment limits established in this section shall be adjusted by the department annually for inflation using the Standard and Poor's DRI Medical Index.~~]

Section 6. Payment Exclusions. Payment shall not include:

(1) The cost of room and board, unless provided as part of respite care in a Medicaid certified nursing facility[~~. If an ABI recipient is placed in a nursing facility to receive respite care, the department shall pay the nursing facility its per diem rate for that individual~~];

(2) The cost of maintenance, upkeep, an improvement, or an environmental modification to a group home or other licensed facility;

(3) Excluding an environmental modification[~~as established in the Acquired Brain Injury Services and Reimbursement Program Manual~~], the cost of maintenance,

upkeep, or an improvement to a recipient's place of residence;

(4) The cost of a service that is not listed in the recipient's approved plan of care; or

(5) A service provided by a family member.

Section 7. Records Maintenance. A participating provider shall:

(1) Maintain fiscal and service records for at least six (6) years;[~~a period of at least five (5) years;~~]

(2) Provide, as requested by the department, a copy of, and access to, each record of the ABI waiver program retained by the provider pursuant to:

(a) Subsection (1) of this section; or

(b) 907 KAR 1:672[~~, Sections 2, 3, and 4~~]; and

(3) Upon request, make available service and financial records to a representative or designee of:

(a) The Commonwealth of Kentucky, Cabinet for Health and Family Services or its designee[~~designated agent~~];

(b) The United States Department for Health and Human Services, Comptroller General;

(c) The United States Department for Health and Human Services, the Centers for Medicare and Medicaid Services (CMS);

(d) The General Accounting Office;

(e) The Commonwealth of Kentucky, Office of the Auditor of Public Accounts; or

(f) The Commonwealth of Kentucky, Office of the Attorney General.

Section 8. [~~Payment Rate for State Fiscal Year (SFY) 2002. With the exception of rates for community residential services, which shall be as established in Section 5 of~~

~~this administrative regulation, effective July 1, 2001 the payment rate that was in effect on June 30, 2001, for an ABI service shall remain in effect.~~

~~Section 9. Payment Rate for State Fiscal Year (SFY) 2003. Effective July 1, 2002, the payment rate that was in effect on June 30, 2002 for an ABI service shall remain in effect.~~

~~Section 10.~~] Appeal Rights. An ABI wavier provider may appeal department decisions as to the application of the administrative regulation as it impacts the provider's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

[~~Section 11.] Incorporation by Reference. (1) "Acquired Brain Injury Services and Reimbursement Program Manual", Department for Medicaid Services, "September 2001 Edition", is incorporated by reference.~~

~~(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, 40621, Monday through Friday, 8 a.m. to 4:30 p.m.~~]

907 KAR 3:100E

REVIEWED:

Date	Elizabeth A. Johnson, Commissioner Department for Medicaid Services

APPROVED:

Date	Janie Miller, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:100E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Diane Pratt (502) 564-5198 or Dana McKenna (502) 564-5198

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the reimbursement provisions relating to home and community based waiver services provided to an individual with an acquired brain injury as an alternative to nursing facility services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the reimbursement provisions relating to home and community based waiver services provided to an individual with an acquired brain injury as an alternative to nursing facility 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 reimbursement provisions relating to home and community based waiver services provided to an individual with an acquired brain injury as an alternative to nursing facility 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 reimbursement provisions relating to home and community based waiver services provided to an individual with an acquired brain injury as an alternative to nursing facility 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: This amendment establishes reimbursement for supervised residential care levels I, II and III; inserts service limits; inserts consumer-directed option (CDO) reimbursement provisions; deletes the annual inflation adjustment factor for upper payment limits; deletes the rate freeze language from prior years; clarifies policy; deleting the manual from the material incorporated by reference as the regulation establishes policy and revising language or formatting to ensure compliance with KRS Chapter 13A.
(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to ensure that providers are reimbursed for provided supervised residential care levels I, II and III.
(c) How the amendment conforms to the content of the authorizing statutes: This amendment amends acquired brain injury waiver service reimbursement within the parameters established by authorizing statutes.
(d) How the amendment will assist in the effective administration of the statutes: This amendment assists in the effective administration of the statutes by estab-

lishes reimbursement for supervised residential care levels I, II and III; inserting service limits; inserting CDO reimbursement provisions and clarifying policy.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: There are twenty-four (24) providers of ABI waiver services.

(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 anticipated.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is anticipated.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The primary benefit is the establishment of a new service category for which DMS will reimburse - supervised residential care level I, II and III.

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

(a) Initially: DMS estimates that the amendment will result in a cost avoidance of $457,200 in the first fiscal year of implementation. The cost avoidances are primarily due to restructuring residential services as previously DMS two (2) levels – a staffed residence reimbursed at $200/day and a group home reimbursed at $90/day. Via the amendment, DMS is customizing the residential service according to the recipient and has established three (3) levels – level I, II and III which will be reimbursed respectively at $200/day, $175/day and $75/day.

(b) On a continuing basis: DMS estimates that the amendment will result in a cost avoidance of $466,200 in the second fiscal year of implementation. The cost avoidances are primarily due to restructuring residential services as previously DMS two levels – a staffed residence reimbursed at $200/day and a group home reimbursed at $90/day. Via the amendment, DMS is customizing the residential service according to the recipient and has established three (3) categories – level I, II and III which will be reimbursed respectively at $200/day, $175/day and $75/day.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act 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: Neither an increase in fees or funding will be necessary to imple-

ment this administrative regulation.

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

(9) Tiering: Is tiering applied? Tiering is not applied as the administrative regulations provisions apply equally to regulated entities. (Explain why tiering was or was not used)

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 3:100E
Agency Contact Person: Diane Pratt (502) 564-5198 or Dana McKenna (502) 564-5198

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

   Yes _X__ No ____
   If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services is affected by this administrative regulation.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 CFR 441.300 – 310.

4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This amendment will not generate revenue for state or local government during the first year of program administration.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This amendment will not generate revenue for state or local government during subsequent years of program administration.

   (c) How much will it cost to administer this program for the first year? This amendment will not result in additional costs during the first year of program administration. To the contrary, DMS estimates that the amendment will result in a cost avoidance of $457,200 in the first fiscal year of implementation. The cost avoidances are primarily due to restructuring residential services as previously DMS two (2) levels – a staffed residence reimbursed at $200/day and a group home reimbursed at $90/day. Via the amendment, DMS is customizing the residential service according to the recipient and has established three (3) levels – level I, II and III which will be reimbursed respectively at $200/da7, $175/day and $75/day.

   (d) How much will it cost to administer this program for subsequent years? This

amendment will not result in additional costs during subsequent years of program administration. To the contrary, DMS estimates that the amendment will result in a cost avoidance of $466,200 in the second fiscal year of implementation. The cost avoidances are primarily due to restructuring residential services as previously DMS two levels – a staffed residence reimbursed at $200/day and a group home reimbursed at $90/day. Via the amendment, DMS is customizing the residential service according to the recipient and has established three (3) categories – level I, II and III which will be reimbursed respectively at $200/da7, $175/day and $75/day.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: No additional expenditures are necessary to implement this amendment.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 3:100E, Payments for acquired brain injury services

Summary of Material Incorporated by Reference

The "Acquired Brain Injury Services and Reimbursement Program Manual", Department for Medicaid Services, "September 2001 Edition", is being un-incorporated by reference from the regulation. . The manual contains 100 pages.