
POLICY TRANSMITTAL NO. 04-48

DATE: SEPTEMBER 3, 2004

OKLAHOMA HEALTH CARE
AUTHORITY

DEPARTMENT OF HUMAN SERVICES
OFFICE OF PLANNING, POLICY & RESEARCH

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:35-17-2 through 35-17-7; 35-17-8.1; 35-17-11; 35-17-12; 35-17-14; 35-17-16; 35-17-19; 35-19-2; 35-19-7.1; 35-19-9; 35-19-18; 35-19-20; and 35-19-22.

EXPLANATION: Medical Assistance for Adults and Children-Eligibility, ADvantage Program Waiver and Nursing Facility Services specific, rules are revised to: (1) update service codes consistent with HIPAA national code requirements; (2) eliminate special code reimbursement for Adult Day Health Facility based respite care; (3) remove the Pre-admission Screening and Resident Review (PASRR) requirement for individuals applying for ADvantage Waiver services; (4) clarify the date used to determine the value of resources for married applicants of ADvantage services; (5) clarify ADvantage waiting list procedures; (6) add consistency concerning case management services in areas where no case management is available; (7) remove physician order requirements for the medical eligibility determination; and (9) clarify UCAT criteria for level of care determinations.

Original signed on 8-30-04

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WF # 04-T (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-3611.

REMOVE

INSERT

317:35-17-2	317:35-17-2, pages 1-8, revised 6-25-04
317:35-17-3	317:35-17-3, pages 1-5, revised 6-25-04
317:35-17-4	317:35-17-4, pages 1-3, revised 6-25-04
317:35-17-5	317:35-17-5, pages 1-4, revised 6-25-04
317:3517-6	-----
317:35-17-7	-----
317:35-17-8.1	-----
317:35-17-11	317:35-17-11, pages 1-7, revised 6-25-04
317:35-17-12	317:35-17-12, 1 page only, revised 6-25-04
317:35-17-14	317:35-17-14, pages 1-5, revised 6-25-04
317:35-17-16	317:35-17-16, 1 page only, revised 6-25-04
317:35-17-19	317:35-17-19, 1 page only, revised 6-25-04
317:35-19-2	317:35-19-2, pages 1-2, revised 6-25-04
317:35-19-7.1	317:35-19-7.1, pages 1-5, revised 6-25-04
317:35-19-9	317:35-19-9, pages 1-6, revised 6-25-04
317:35-19-18	317:35-19-18, 1 page only, revised 6-25-04

REMOVE

317:35-19-20

317:35-19-22

INSERT

317:35-19-20, pages 1-7, revised 6-25-04

317:35-19-22, 1 page only, revised 6-25-04

317:35-17-2. Level of care medical eligibility determination

The OKDHS area nurse, or nurse designee, determines medical eligibility for ADvantage program services based on the Long Term Care (LTC) nurse's Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the client has unmet care needs that require ADvantage or NF services to assure client health and safety. ADvantage services are initiated to support the informal care that is being provided in the client's home, or, that based on the UCAT, can be expected to be provided in the client's home upon discharge of the client from a NF or hospital. These services are not intended to take the place of regular care provided by family members and/or by significant others. When there is an informal (not paid) system of care available in the home, ADvantage service provision will supplement the system within the limitations of ADvantage Program policy.

(1) **Definitions.** The following words and terms when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(A) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the client's ability to perform self-care tasks essential for sustaining health and safety such as:

(i) bathing,

(ii) eating,

(iii) dressing,

(iv) grooming,

(v) transferring (includes getting in and out of a tub, bed to chair, etc.),

(vi) mobility,

(vii) toileting, and

(viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the client's total weighted UCAT ADL score is 10 or more which indicates the

client needs some help with 5 ADLs or that the client cannot do 3 ADLs at all plus the client needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means client's total weighted UCAT ADL score is 8 or 9 which indicates the client needs help with 4 ADLs or the client cannot do 3 ADLs at all.

(D) **"CHC"** means Comprehensive Home Care.

(E) **"Client Support high risk"** means client's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the client requires additional care that is not available through Medicare, Veterans Administration, or other Federal entitlement programs.

(F) **"Client Support moderate risk"** means client's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the client requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

(G) **"Cognitive Impairment"** means that the person, as determined by the clinical judgment of the LTC Nurse or the AA, does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on MSQ performance in combination with a more general evaluation of cognitive function from interaction with the person during the UCAT assessment.

(H) **"Developmental Disability"** means a severe, chronic

disability of an individual that:

(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(ii) is manifested before the individual attains age 22;

(iii) is likely to continue indefinitely;

(iv) results in substantial functional limitations in three or more of the following areas of major life activity:

(I) self-care;

(II) receptive and expressive language;

(III) learning;

(IV) mobility;

(V) self-direction;

(VI) capacity for independent living; and

(VII) economic self-sufficiency; and

(v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

(I) **"Environment high risk"** means client's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(J) **"Environment moderate risk"** means client's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(K) "Health Assessment high risk" means client's UCAT health assessment score is 25 which indicates in the UCAT assessor's

clinical judgment, the client has one or more chronic health conditions, whose symptoms are rapidly deteriorating, uncontrolled, or not well controlled and requiring a high frequency or intensity of medical care/oversight to bring under control and whose functional capacity is so limited as to require full time assistance or care performed daily, by, or under the supervision of professional personnel and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and requires NF placement immediately if these needs cannot be met by other means.

(L) "Health Assessment low risk" means client's health assessment score is 5 which indicates, in the UCAT assessor's clinical judgment, the client has one or more chronic, stable, health conditions, whose symptoms are controlled or nearly controlled, which benefit from available, or usually available, medical treatment or corrective measures, and may have an unmet need for a service available only through the ADvantage program or a Nursing Facility (NF) but is not likely to enter a NF if these needs are not met.

(M) "Health Assessment moderate risk" means client's UCAT Health Assessment score is 15 which indicates in the UCAT assessor's clinical judgment, the client has one or more chronic changing health conditions, whose symptoms are fragile or worsening and require medical care/oversight, to bring under control or to maintain in a stable, controlled state and has multiple unmet needs for services available only through the ADvantage program or a Nursing Facility (NF) and is likely to enter a NF if these needs are not met.

(N) "IADL" means the instrumental activities of daily living.

(O) "IADLs score in high risk range" means client's total weighted UCAT IADL score is 12 or more which indicates the client needs some help with 6 IADLs or cannot do 4 IADLs at all.

(P) "Instrumental activities of daily living" means those activities that reflect the client's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- (i) shopping,
- (ii) cooking,
- (iii) cleaning,
- (iv) managing money,
- (v) using a telephone,
- (vi) doing laundry,
- (vii) taking medication, and
- (viii) accessing transportation.

(Q) **"Mental Retardation"** means that the person has, as determined by a PASRR level II evaluation, substantial limitations in functional ability due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

(R) **"MSQ"** means the mental status questionnaire.

(S) **"MSQ score in high risk range"** means the client's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(T) **"MSQ score at the high end of the moderate risk range"** means the client's total weighted UCAT MSQ score is (10) or (11) which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

(U) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the client has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

(V) **"Progressive degenerative disease process that responds to treatment"** means a process such as, but not limited to, Multiple Sclerosis (MS), Parkinson's Disease, Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS), that, untreated, systematically impairs

normal body function which leads to acute illness and/or disability but that reacts positively to a medically prescribed treatment intervention (usually medication) which arrests or significantly delays the destructive action of the process.

(W) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more, which indicates the client lives alone, combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria.** The minimum UCAT criteria for NF level of care criteria are:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

(II) MSQ score is at the high end of moderate risk range; or,

(III) IADLs score is in the high risk range; or,

(IV) Nutrition score is in the high risk range; or,

(V) Health Assessment is in the moderate risk range, and, in addition;

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Client Support is moderate risk; or,

(ii) Environment is high risk; or,

(iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria

under (A) of need and (B) of absence of support are met;

(C) The UCAT documents that:

(i) the client has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:35-17-2(2)(A) criteria if untreated; and

(ii) the client previously has required Hospital or NF level of care services for treatment related to the condition; and

(iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and

(iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical, mental and/or functional impairments;

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to adequately and appropriately care for self or communicate needs to others;

(E) require medical care and treatment in order to minimize physical health regression or deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal

**MEDICAL ASSISTANCE FOR ADULTS
AND CHILDREN-ELIGIBILITY**

OAC 317:35-17-2 (p8)

entitlement program with the exception of Indian Health Services; and

(G) require care that cannot be met through Medicaid State Plan Services, including Personal Care, if financially eligible.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community Based Waiver used to finance noninstitutional long-term care services for elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a 30 day period, the person's health, due to disease process or disability, would, without appropriate services, deteriorate and require nursing facility care to arrest the deterioration. ADvantage program clients must be Medicaid eligible and must not reside in an institution, room and board, licensed residential care facility, or licensed assisted living facility. The number of clients who may receive ADvantage services is limited.

(1) To receive ADvantage services, individuals must meet one of the following categories:

(A) be age 65 years or older, or

(B) be age 21 or older if physically disabled and not developmentally disabled or if the person has a clinically documented, progressive degenerative disease process that responds to treatment and previously has required hospital or NF level of care services for treatment related to the condition and requires ADvantage services to maintain the treatment regimen to prevent health deterioration, or

(C) if developmentally disabled and between the ages of 21 and 65, not have mental retardation or a cognitive impairment related to the developmental disability.

(2) In addition, the individual must meet the following criteria:

(A) require nursing facility level of care [see OAC 317:35-17-2];

(B) meet service eligibility criteria [see OAC 317:35-17-3(d)]; and

(C) meet program eligibility criteria [see OAC 317:35-17-3(e)].

(b) Home and Community Based Waiver Services are outside the scope of state plan Medicaid services. The Medicaid waiver allows the

OHCA to offer certain Home and Community Based services to an annually capped number of persons who are categorically needy (refer to OKDHS Appendix C-1, Schedule VIII. B. 1.) and without such services would be institutionalized. The estimated cost of providing an individual's care outside the nursing facility cannot exceed the annual cost of caring for that individual in a nursing facility. When determining the ADvantage service plan cost cap for an individual, the comparable Medicaid cost to serve that individual in a nursing facility is estimated. If the individual has Acquired Immune Deficiency Syndrome (AIDS) or if the individual requires ventilator care, the appropriate Medicaid enhanced nursing facility rate to serve the individual is used to estimate the ADvantage cost cap. To meet program cost effectiveness eligibility criteria, the annualized cost of a client's ADvantage services cannot exceed the ADvantage program services expenditure cap unless approved by the Administrative Agent (AA) under one of the exceptions listed in (1)-(4) of this subsection. The cost of the service plan furnished to a client may exceed the expenditure cap only when all of the increased expenditures above the cap are due solely to:

(1) a one-time purchase of home modifications and/or specialized medical equipment; and/or

(2) documented need for a temporary (not to exceed a 60-day limit) increase in frequency of service or number of services to prevent institutionalization; or

(3) expenditures are for ADvantage Hospice services; and/or,

(4) expenditures in excess of the cap are for prescribed drugs, which would be paid by Medicaid if the individual were receiving services in a nursing home, and the annualized expenditures for ADvantage services to a client under these circumstances can reasonably be expected to be no more than 200% of the individual cap.

(c) Services provided through the ADvantage waiver are:

(1) case management or Comprehensive Home Care (CHC) case management;

(2) respite or CHC in-home respite;

(3) adult day health care;

- (4) environmental modifications;
 - (5) specialized medical equipment and supplies;
 - (6) physical therapy/occupational therapy/respiratory therapy/speech therapy or consultation;
 - (7) advanced supportive/restorative assistance or CHC advanced supportive/restorative assistance;
 - (8) skilled nursing or CHC skilled nursing;
 - (9) home delivered meals;
 - (10) hospice care;
 - (11) medically necessary prescription drugs within the limits of the waiver;
 - (12) personal care (state plan), ADvantage personal care, or CHC personal care;
 - (13) Personal Emergency Response System (PERS); and
 - (14) Medicaid medical services for individuals age 21 and over within the scope of the State Plan.
- (d) The OKDHS area nurse or nurse designee makes a determination of service eligibility prior to evaluating the UCAT assessment for nursing facility level of care. The following criteria are used to make the service eligibility determination:
- (1) an open ADvantage Program waiver slot, as authorized by the waiver document approved by the Centers for Medicare and Medicaid Services (CMS), is available to assure federal participation in payment for services to the client. If the AA determines all ADvantage waiver slots are filled, the client cannot be certified on the OKDHS computer system as eligible for ADvantage services and the client's name is placed on a waiting list for entry as an open slot becomes available. ADvantage waiver slots and corresponding waiting lists, if necessary, are maintained for persons that have a developmental disability and those that do not have a developmental disability.

(2) the client is in the ADvantage targeted service group. The target group is an individual who is frail and 65 years of age or older or age 21 or older with a physical disability and who does not have mental retardation or a cognitive impairment.

(3) the client does not pose a physical threat to self or others as supported by professional documentation.

(4) members of the household or persons who routinely visit the household, as supported by professional documentation, do not pose a threat of harm or injury to the client or other household visitors.

(e) The AA determines ADvantage program eligibility through the service plan approval process. The following criteria are used to make the ADvantage program eligibility determination that a client is not eligible:

(1) if the client's needs as identified by UCAT and other professional assessments cannot be met through ADvantage program services, Medicaid State Plan services and other formal or informal services. The State, as part of the waiver program approval authorization, assures CMS that each waiver client's health, safety, or welfare can be maintained in their home. If a client's identified needs cannot be met through provision of ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the client's health, safety or welfare in their home cannot be assured.

(2) if the client poses a physical threat to self or others as supported by professional documentation.

(3) if other members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the client or other household visitors.

(4) if the client's needs are being met, or do not require ADvantage services to be met, or if the client would not require institutionalization if needs are not met.

(5) if, after the service and care plan is developed, the risk to client health and safety is not acceptable to the client, or to the interdisciplinary service plan team, or to the AA.

(f) The case manager provides the AA with professional documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the service plan as provider safety permits until the client is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, the AA will provide technical assistance to the Provider for transitioning the client to other services.

(g) Individuals determined ineligible for ADvantage program services are notified in writing by OKDHS of the determination and of their right to appeal the decision.

(h) The AA provides OKDHS with notification that the client is no longer program eligible.

317:35-17-4. Application for ADvantage services

(a) **Application procedures for ADvantage services.** If waiver slots are available, the application process is initiated by the receipt of a UCAT, Part I or by an oral request for services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form. ■1

(2) An individual residing in an NF or requesting waiver services, or the individual's community spouse may request an assessment of resources available to each spouse by using OKDHS form MA-11, Assessment of Assets, when Medicaid application is not being made. The individual and/or spouse must provide documentation of resources. The assessment reflects all countable resources of the couple (owned individually or as a couple) and establishes the spousal share to be protected when subsequent determination of Medicaid long-term care eligibility is made. ■2

(3) When Medicaid application is being made, an assessment of resources must be completed if it was not completed when the individual entered the NF or began receiving waiver services. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources. If the individual applies for Medicaid at the time of entry into the ADvantage waiver, Form MA-11 is not appropriate. However, the spousal share must be determined using the resource information provided on the Medicaid application form and computed using OKDHS form MA-12, Title XIX Worksheet.

(b) **Date of application.**

(1) The date of application is:

(A) the date the applicant or someone acting in his/her behalf signs the application in the county office; or

(B) the date the application is stamped into the county office when the application is initiated outside the county office; or

(C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.

(2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the client's county of residence for Medicaid eligibility determination. The application date is the date the client signed the application form for the provider.

(c) **ADvantage waiting list procedures.** ADvantage Program "available capacity in the month" is the number of additional clients that may be enrolled in the Program in a given month without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. The available capacity in the month for any particular month is calculated as follows: Available capacity in the month equals [(Waiver year C value) minus (unduplicated number during the current waiver fiscal year served as of the last day of the previous month)] divided by (the number of months remaining in the waiver year). Upon notification from the AA that 102% of the available capacity in the previous month was exceeded, OKDHS Aging Services Division (OKDHS/ASD) notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II that, until further notice, requests for ADvantage services are not to be processed as applications, but referred to AA to be placed on a waiting list of requests for ADvantage services. Up to a maximum of five requests for ADvantage Program services from individuals who have resided in a nursing facility for a minimum of two months and who are transitioning from nursing facility to home-based care under Oklahoma's Real Choice Systems Change Nursing Facility Transition Services Pilot are exempt from waiting list procedures. Upon implementation and for the duration of waiting list

procedures, the SPEED policy described under OAC 317:35-17-17 is suspended except for persons identified through the Nursing Facility Transition Services Pilot as being exempt from waiting list procedures.

(1) Each month as additional waiver slots are available, the AA forwards requests from the waiting list to the appropriate OKDHS county office for processing the application.

(2) The criterion for suspending waiting list procedures is the occurrence of two consecutive months in which no person is retained on the waiting list the entire month and less than 95% of the available capacity in the month is attained. Upon notification from the AA that waiting list procedures are no longer necessary, OKDHS/ASD notifies OKDHS county offices and contract agencies approved to complete the UCAT, Parts I and II to process requests for ADvantage services as applications.

INSTRUCTIONS TO STAFF

1. When the application is completed and signed, the computer input form is prepared and registered on the DHS computer system within five days of the application date.
2. A copy of Form MA-11 is provided to each spouse for planning in regard to future financial eligibility and a copy is retained in the county office in case of subsequent application.

317:35-17-5. ADvantage program medical eligibility determination

The OKDHS area nurse, or nurse designee, makes the medical eligibility determination utilizing professional judgment, the Uniform Comprehensive Assessment Tool (UCAT), Part III, and other available medical information.

(1) When ADvantage care services are requested or the UCAT is received in the county office:

(A) the LTC nurse is responsible for completing the UCAT.

(B) the social worker is responsible for contacting the individual within three working days to initiate the financial eligibility application process.

(2) Categorical relationship must be established for determination of eligibility for ADvantage services. If categorical relationship to disability has not already been established, the local social worker submits the same information described in OAC 317:35-5-4(2) to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up is required by the OKDHS social worker with the Social Security Administration to be sure their disability decision agrees with the decision of LOCEU.

(3) Community agencies complete the UCAT, Part I and forwards the form to the county office. If the UCAT, Part I indicates that the applicant does not qualify for Medicaid long-term care services, the applicant is referred to appropriate community resources.

(4) The LTC nurse completes the UCAT, Part III assessment visit with the client within 10 working days of receipt of the referral for ADvantage services for a client who is Medicaid eligible at the time of the request. The LTC nurse completes the UCAT, Part III assessment within 20 working days of the date the Medicaid application is completed for new clients.

(5) During the assessment visit, the LTC nurse informs the client of medical eligibility and provides information about the different long-term care service options. If there are multiple

household members applying for the ADvantage program, the UCAT assessment is done for the applicant household members during the same visit. The LTC nurse documents whether the client chooses NF program services or ADvantage program services. In addition, the LTC nurse makes a level of care and service program recommendation.

(6) The LTC nurse informs the client and family of agencies certified to deliver ADvantage case management and in-home care services in the local area to obtain the client's primary and secondary informed choices.

(A) If the client and/or family declines to make a provider choice, the LTC nurse documents that decision on the client choice form.

(B) The AA uses a rotating system to select an agency for the client from a list of all local certified case management and in-home care agencies.

(7) The LTC nurse documents the names of the chosen agencies and the agreement (by dated signature) of the client to receive services provided by the agencies.

(8) If the needs of the client require an immediate interdisciplinary team (IDT) meeting with home health agency nurse participation to develop a care plan and service plan, the LTC nurse documents the need.

(9) The LTC nurse scores the UCAT, Part III. The LTC nurse forwards the UCAT, Parts I and III, documentation of financial eligibility, and documentation of the client's case management and in-home care agency choices to the area nurse, or nurse designee, for medical eligibility determination.

(10) If, based upon the information obtained during the assessment, the LTC nurse determines that the client may be at risk for health and safety, OKDHS Adult Protective Services (APS) staff are notified immediately and the referral is documented on the UCAT.

(11) Within ten working days of receipt of a complete ADvantage application, the area nurse, or nurse designee, determines medical eligibility using NF level of care criteria and service eligibility criteria [refer to OAC 317:35-17-2 and OAC 317:35-

17-3] and enters the medical decision on the system. The original documents are sent with the MS-52 to the AA.

(12) Upon notification of financial eligibility from the social worker, medical eligibility (MS-52) and approval for ADvantage entry from the area nurse, or nurse designee, the AA communicates with the client and case management provider to begin care plan and service plan development. The AA communicates to the client's case management provider the client's name, address, case number and social security number, the units of case management and, if applicable, the number of units of home health agency nurse evaluation authorized for care plan and service plan development, whether the needs of the client require an immediate IDT meeting with home health agency nurse participation and the effective date for client entry into ADvantage.

(13) If the services must be in place to ensure the health and safety of the client upon discharge to the home from the NF, the AA provides administrative case management to develop and implement the care plan and service plan. For administrative case management, the AA, or a nurse case manager from an ADvantage case management provider selected by the client and referred by the AA follows ADvantage case management procedures for care plan and service plan development and implementation. If the AA has provided transition case management services, when the client returns home, the AA begins transitioning case management to the ADvantage case management provider chosen by the client.

(14) If a client in a hospital requests ADvantage services, the hospital initiates a request for Medicaid ADvantage services by contacting the AA for intake and screening.

(A) The AA, or a nurse case manager from an ADvantage case management provider selected by the client and referred by the AA completes the UCAT, Part III assessment visit, if possible, with the hospitalized applicant. If the local OKDHS office receives the request for Medicaid ADvantage services for a client in a hospital it is referred to the AA.

During the assessment visit, the AA, or ADvantage nurse case manager informs the client of financial and medical eligibility criteria and provides information about the different long-term care service options. The AA, or ADvantage nurse case manager documents the client's choice on

the UCAT, Part III. The AA, or ADvantage nurse case manager will review forms documenting the selection of provider(s), agreement with the service plan and release of information with the client and obtain the client's dated signature on the forms.

(B) If the UCAT indicates the client is eligible for ADvantage services and financial eligibility has been determined, the AA, or ADvantage nurse case manager, in consultation with the hospital discharge planner provides administrative case management. The AA, or ADvantage nurse case manager develops a temporary care plan and service plan if services must be in place to ensure the health and safety of the client upon discharge from the hospital. When the client returns home, the AA, or ADvantage nurse case manager transitions case management to the ADvantage case management provider chosen by the client.

(C) The completed assessment forms are submitted to the OKDHS area nurse who makes the medical eligibility decision, enters it on the system and notifies the AA of the decision.

(D) If the applicant is determined not eligible for ADvantage, providers follow special procedures specified by the AA to bill for services provided. If authorized by the AA, case management providers may bill using an administrative case management procedure code for services delivered and not reimbursable under any other ADvantage case management procedure code.

(15) If the client has a current certification and requests a change from Personal Care Services to ADvantage services, a new UCAT is required. The UCAT is updated when a client requests a change from ADvantage services to Personal Care services, or when a client requests a change from the nursing facility to ADvantage services. If a client is receiving ADvantage services and requests to go to a nursing facility, a new medical level of care decision is not needed.

(16) When a UCAT assessment has been completed more than 90 days prior to submission to the area nurse or nurse designee for a medical decision, a new assessment is required.

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds that standard, refer to Medicaid rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41(d)(9)(F)(ii)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum reserve standard for an individual listed in OKDHS Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program there is not a spenddown calculation as the client does not pay a vendor payment.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum reserve standards, certification is delayed up to 30 days

providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(2) Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital. For an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of ADvantage program services.

(A) Income eligibility. Income is determined separately for an individual and his/her spouse if the spouse is in the ADvantage or HCBW/MR program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of ADvantage services. The rules in (i) - (v) of this subparagraph apply in this situation:

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of

the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to Medicaid rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41(d)(9)(F)(ii)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum reserve standard for an individual listed in OKDHS Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program, there is no spenddown calculation as the client does not pay a vendor payment.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum reserve standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in the ADvantage or HCBW/MR program.** When only one individual of a couple in their own home is in the ADvantage or HCBW/MR program, income and resources are determined separately. However, the income and resources of the individual who is not in the ADvantage or HCBW/MR program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in ADvantage program services, the income of the community spouse is not considered available to that individual. The following rules

are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the ADvantage program services cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to Medicaid rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41(d)(9)(F)(ii)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the ADvantage program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving ADvantage program services. The amount determined as the spousal share is used for all subsequent applications for Medicaid, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for Medicaid is made at the same time the individual begins receiving ADvantage program services, Form MA-12, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the ADvantage program services (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Appendix C-1, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. ■1 If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for Medicaid. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of Medicaid eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for Medicaid, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving

ADvantage program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum reserve for an individual as shown in OKDHS Appendix C-1, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent Medicaid application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for Medicaid is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance shall be held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

(I) the community spouse's monthly income allowance;

(II) the amount of monthly income otherwise available to the community spouse;

(III) determination of the spousal share of resource;

(IV) the attribution of resources (amount deemed); or

(V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Vendor payment.** There is not a spenddown calculation for individuals receiving ADvantage program services as the client does not pay a vendor payment.

(D) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum reserve standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

INSTRUCTIONS TO STAFF

1. The computation for the community spouse's share of resources is:
 - A. Total Countable Resources
 - B. Divided by 2 (Cannot exceed the maximum resource standard. If less than the minimum resource standard, deem from spouse up to the minimum standard).

317:35-17-12. Certification for ADvantage program services

(a) **Application date.** If the applicant is found eligible for Medicaid, certification may be effective the date of application. The first month of the certification period must be the first month the recipient was determined eligible for ADvantage, both financially and medically.

(1) As soon as eligibility or ineligibility for ADvantage program services is established, the social worker updates the computer form and the appropriate notice is computer generated to the client and the Administrative Agent. Notice information is retained on the notice file for county use.

(2) An applicant approved for ADvantage program services as categorically needy is mailed a Medical Identification Card.

(b) **Financial certification period for ADvantage program services.**

The financial certification period for the ADvantage program services is 12 months. Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical Certification period for ADvantage program services.**

The area nurse, or nurse designee, determines the medical certification period for medical services and establishes a medical redetermination review date. This certification period may be up to 36 months. The area nurse, or nurse designee, may determine a certification period less than 36 months if documentation supports a reasonable expectation that the client will not continue to meet medical eligibility criteria or have a need for long term care services for a 36 month period. A medical eligibility period of less than 36 months may be appropriate in circumstances in which rehabilitation from surgery or injury is expected or if services are needed on a temporary basis to assist the client to regain independence.

317:35-17-14. Case Management services

(a) Case management services involve ongoing assessment, service planning and implementation, service monitoring and evaluation, client advocacy, and discharge planning.

(1) Within one working day of receipt of an ADvantage referral from the AA, the case management supervisor assigns a case manager to the client. Within three working days of being assigned an ADvantage client, the case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the client, service provider, case manager, Administrative Agent and OKDHS in the program), and review, update and complete the UCAT assessment, and to discuss service needs and ADvantage service providers. The Case Manager notifies in writing the client's UCAT identified primary physician that the client has been determined eligible to receive ADvantage services. The notification is via a preprint form that contains the client's signed permission to release this health information and requests physician's office verification of primary and secondary diagnoses and diagnoses code obtained from the UCAT.

(2) Within 10 working days of the receipt of ADvantage referral, or the annual re-assessment visit, the case manager completes and submits to the case management supervisor an individualized care plan and service plan for the client. The care plan and service plan are based on the client's service needs identified by the UCAT, Part III, and includes only those ADvantage services required to sustain and/or promote the health and safety of the client. The case manager uses an interdisciplinary team (IDT) planning approach for care plan and service plan development. If in-home care is the primary service, the IDT includes, at a minimum, the client, a nurse from the ADvantage in-home care provider chosen by the client, and the case manager. Otherwise, the client and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, challenges to meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The case manager identifies services, service provider, funding source, units and frequency of service and service cost, cost by funding source and total cost for ADvantage services. The client signs and indicates review/agreement with the care plan and service plan

by indicating acceptance or non-acceptance of the plans. The client, the client's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the client signs with a mark. If the client refuses to cooperate in development of the service plan, or, if the client refuses to sign the service plan, the case management agency refers the case to the AA for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the LTC nurse or AA may identify clients that require AA intervention.

(A) For clients that are uncooperative or disruptive, the AA develops an individualized Addendum to the Rights and Responsibilities Agreement to try to modify the client's uncooperative/disruptive behavior. The rights and responsibilities addendum focuses on behaviors, both favorable and those that jeopardize the consumer's well-being and includes a design approach of incremental plans and addenda that allow the client to achieve stepwise successes in the modification of their behavior.

(B) The AA may implement a service plan without the client's signature if the AA has developed an Addendum to the Rights and Responsibilities Agreement for the client. For these clients the presence of a document that "requires" their signature may itself trigger a "conflict". In these circumstances, mental health/behavioral issues may prevent the client from controlling their behavior to act in their own interest. Since the person by virtue of level of care and the IDT assessment, needs ADvantage services to assure their health and safety, the AA may implement the service plan if the AA demonstrates effort to work with and obtain the client's agreement through an individualized Addendum to the Rights and Responsibilities Agreement. Should negotiations not result in agreement with the care plan and service plan, the client may withdraw their request for services or request a fair hearing.

(4) The case manager submits the care plan and service plan to the case management supervisor for review. The case management supervisor documents the review/approval of the plans within two working days of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. The case manager re-submits the

corrected care plan and service plan to the case management supervisor within two working days. The case management supervisor returns the approved care plan and service plan to the case manager. Within one working day of receiving supervisory approval, the case manager makes a copy of the plans and other client original documents for the client file, faxes a copy of the plan to the AA and forwards the original care plan and service plan and required documents.

(5) Within one working day of notification of care plan and service plan authorization, the case manager communicates with the service plan providers and with the client to facilitate service plan implementation. Within one working day of receipt of a copy or the computer-generated authorized service plan from the AA, the case manager sends (by mail or fax) copies of the authorized service plan or computer-generated copies to providers. Within five working days of notification of an initial or new service plan authorization, the case manager visits the client, gives the client a copy of the service plan or computer-generated copy of the service plan and evaluates the progress of the service plan implementation. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and

(B) monthly after the initial 30 day follow-up evaluation date.

(b) Authorization of service plans and amendments to service plans.

The Administrative Agent certifies the individual service plan and all service plan amendments for each ADvantage client. When the AA verifies client ADvantage eligibility, plan cost effectiveness, that service providers are ADvantage authorized and Medicaid contracted, and that the delivery of ADvantage services are consistent with the client's level of care need, the service plan is authorized. Family members may not receive payment for providing ADvantage waiver services. A family member is defined as an individual who is legally responsible for the client (spouse or parent of a minor child).

(1) If the service plan authorization or amendment request packet received from case management is complete and the service plan is within cost effectiveness guidelines, the AA authorizes

or denies authorization within three working days of receipt of the request. If the service plan authorization or amendment request packet received from case management is complete and the service plan is not within cost-effectiveness guidelines, the plan is referred for administrative review to develop an alternative cost-effective plan or assist the client to access services in an alternate setting or program. If the request packet is not complete, the AA notifies the case manager immediately and puts a "hold" on authorization until the required additional documents are received from case management.

(2) The AA authorizes the service plan by entering the authorization date and signing the submitted service plan. Notice of authorization and a copy of the authorized plan or a computer-generated copy of the authorized plan are provided to case management. AA authorization determinations are provided to case management within one working day of the certification date. A service plan may be authorized and implemented with specific services temporarily denied. The AA communicates to case management the conditions for approval of temporarily denied services. The case manager submits revisions for denied services to AA for approval.

(3) For audit purposes (including SURS reviews), the computer-generated copy of the authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. State or Federal quality review and audit officials may obtain a copy of specific service plans with original signatures by submitting a request to the AA.

(c) **Change in service plan.** The process for initiating a change in the service plan is described in this subsection.

(1) The service provider initiates the process for an increase or decrease in service to the client's service plan. The requested changes and justification for them are documented by the service provider and, if initiated by a direct care provider, submitted to the client's case manager. If in agreement, the case manager requests the service changes on a care plan and service plan amendment submitted to the AA. The AA approves or denies the care plan and service plan changes within two working days of receipt of the plan.

(2) A significant change in the client's physical condition or caregiver support, one that requires additional goals, deletion

of goals or goal changes, or requires a four-hour or more adjustment in services per week, requires a UCAT reassessment by the case manager. The case manager, in consultation with AA, makes the determination of need for reassessment. Based on the reassessment and consultation with the AA, the client may, as appropriate, be authorized for a new service plan or be eligible for a different service program. If the client is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the client's dated signature indicating voluntary withdrawal for ADvantage program services. If unable to obtain the client's consent for voluntary closure, the case manager requests assistance from the AA. The AA requests that the OKDHS area nurse initiate a reconsideration of level of care. If the client's service needs are different or have significantly increased, the case manager develops an amended or new service plan and care plan, as appropriate, and submits the new/amended plans for authorization.

317:35-17-16. Client annual level of care re-evaluation and annual re-authorization of service plan

(a) As part of the fourth quarter monitoring of the service plan for years 1 and 2 for the client, the case manager reassesses the client's needs and the client's care plan and service plan, especially with respect to progress of the client toward care plan and service plan goals and objectives. Based on the reassessment, the case manager develops a new care plan and service plan with the client and service providers, as appropriate, and submits the new care plan and service plan to the AA for certification. Along with the care plan and service plan submitted for annual recertification, the case manager forwards to AA the supporting documentation and the assessment of the existing service plan and care plan. The case manager initiates the fourth quarter monitoring to allow sufficient time for certification of a new care plan and service plan prior to the expiration date on the existing care plan and service plan.

(b) For ADvantage, annual medical recertification of the client is not required. However, the AA will evaluate whether the client continues to meet minimum criteria for medical eligibility as part of the care plan and service plan recertification process. If the client appears not to meet NF level of care, the AA requests the LTC nurse to complete a UCAT, Parts I and III. The LTC nurse submits the UCAT to the area nurse, or nurse designee, for determination of medical eligibility. The area nurse, or nurse designee, sends the client's redetermined MS-52 to the AA. If the client no longer meets medical eligibility, the AA communicates this to the client's case manager. The case manager communicates with the client and if requested, helps the client to arrange alternate services in place of ADvantage. [See OAC 317:35-17-19(b)]

(c) At a maximum of every 36 months, the LTC nurse makes a home visit to evaluate the ADvantage client using the UCAT, Parts I and III. The LTC nurse evaluation substitutes for the case manager's fourth quarter assessment in the client's third year. The LTC nurse submits the UCAT evaluation to the area nurse, or nurse designee, for a determination of continued medical eligibility before case management develops a care plan and new service plan. The LTC nurse initiates the third year evaluation to allow sufficient time for certification of a new care plan and service plan prior to the expiration date on the existing care plan and service plan.

317:35-17-19. Closure or termination of ADvantage services

(a) **Voluntary closure of ADvantage services.** If the client requests a lower level of care than ADvantage services or if the client agrees that ADvantage services are no longer needed to meet his/her needs, a medical decision by the area nurse, or nurse designee, is not needed. The closure request is completed and signed by the client and the case manager and sent to the AA to be placed in the client's case record. The AA notifies the OKDHS county office of the voluntary closure and effective date of closure. The case manager documents in the case record all circumstances involving the reasons for the voluntary termination of services and alternatives for services if written request for closure cannot be secured.

(b) **Closure due to financial or medical ineligibility.** The process for closure due to financial or medical ineligibility is described in this subsection.

(1) **Financial ineligibility.** Anytime the local OKDHS office determines a client does not meet the financial eligibility criteria, the local OKDHS office notifies the client, provider, and AA of financial ineligibility. A medical eligibility redetermination is not required when a financial ineligibility period does not exceed the medical certification period.

(2) **Medical ineligibility.** Any time the local OKDHS office is notified through MEDATS of a decision that the individual is no longer medically eligible for ADvantage services, the local office notifies the individual, AA and provider of the decision.

(c) **Closure due to other reasons.** Refer to OAC 317:35-17-3(e) - (h).

(d) **Resumption of ADvantage services.** If a client approved for ADvantage services has been without services for less than 90 days and has a current medical and financial eligibility determination, services may be resumed using the previously approved service plan. If a client decides he/she desires to have his/her services restarted after 90 days, the client must request the services as a new referral through the county office.

317:35-19-2. Nursing Facility (NF) program medical eligibility determination

The OKDHS area nurse, or nurse designee (OHCA, LOCEU makes some determinations when PASRR is involved), determines medical eligibility for nursing facility (NF) services based on the Long Term Care (LTC) nurse's UCAT, Part III assessment of the client's needed level of care, the outcome of the Level II Preadmission Screening and Resident Review (PASRR), if completed, and professional judgment. Refer to OAC 317:35-19-7.1(3) for nursing facility level of care medical eligibility requirements.

(1) When NF care services are requested prior to admission, the same rules related to medical eligibility determination identified in OAC 317:35-17-5 for ADVantage services are followed.

(2) The LTC nurse submits the UCAT, Part III, the Long-Term Care Preadmission Screen form (PASRR), and the NF request for assessment to the area nurse, or nurse designee, for medical eligibility determination.

(3) PASRR requirements are identified in OAC 317:35-19-8 and 317:35-19-9.

(4) When it is not possible for the UCAT assessment to be completed prior to admission, the NF is responsible for notifying the OKDHS of the admission. Notification will be by mailing or by faxing the OKDHS form ABCDM-83 (Notification Regarding Patient In A Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice), OKDHS form ABCDM-96 (Management of Recipient's Funds), and OKDHS form ABCDM-83-A, Request for Title XIX Nursing Assessment, to the local OKDHS county office. Upon receipt, the OKDHS county office processes the ABCDM-83, ABCDM-96, and the ABCDM-83-A and completes and forwards the OKDHS form ABCDM-37D (Notice Regarding Financial Eligibility) to the NF. Identified sections of the UCAT reflecting the domains for meeting medical criteria are completed for applicants residing in the NF at the time of assessment. The area nurse, or nurse designee, determines the date of medical eligibility and records it on the system based on the date of financial eligibility. The facility is responsible for performing the PASRR Level I screen and consulting with staff of the OHCA as to whether a need exists for a Level II screen. The LTC nurse will conduct the

assessment visit within 15 working days of request for assessment if the individual's needs are included in an active ABCDM case. If the individual's needs are not included in an active ABCDM case, the assessment is conducted within 20 working days of the date of the signed application. The LTC nurse forwards the completed preadmission screen, the ABCDM-83-A, and the UCAT, Part III to the area nurse or nurse designee.

(5) The area nurse, or nurse designee, will evaluate the PASRR Level I screen and the UCAT, Part III and consult with staff of the OHCA as to whether a need exists for a Level II screen as necessary.

(6) The area nurse, or nurse designee, will evaluate the UCAT, Parts I and III, the Long-Term Care Preadmission Screen form and the physician's diagnosis to determine whether the applicant meets the medical eligibility criteria for NF level of care. Individuals may be medically certified for NF level of care for various lengths of time depending upon the needs of the client. The area nurse, or nurse designee, enters the medical eligibility decision, and when required, the medical certification review date on the system within ten working days. A medical eligibility redetermination is not required when a client is discharged from the NF for a period not to exceed 90 days and the original certification is current.

(7) If the LTC nurse recommends NF level of care and the client is determined by the area nurse, or nurse designee, not to be medically eligible for NF level of care, the LTC nurse can submit additional information to the area nurse, or nurse designee. When necessary, a visit by the LTC nurse to obtain additional information can be initiated at the recommendation of the area nurse, or nurse designee.

(8) Categorical relationship must be established for determination of eligibility for NF services. If categorical relationship to disability has not already been established, the worker submits the same information described in OAC 317:35-5-4(2) to the LOCEU to request a determination of eligibility for categorical relationship. LOCEU renders a decision on categorical relationship to the disabled using the same definition used by SSA. A follow-up with the SSA by the OKDHS worker is required to be sure that the SSA disability decision agrees with the decision of LOCEU.

317:35-19-7.1. Level of care medical eligibility determination

The OKDHS area nurse, or nurse designee (OHCA, LOCEU makes some determinations when PASRR is involved), determines medical eligibility for the ADvantage program or nursing facility services based on the LTC nurse's UCAT III assessment, outcome of the Level II PASRR, if completed, and professional judgment.

(1) **Definitions.** The following words and terms when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

(A) **"ADL"** means the activities of daily living. Activities of daily living are activities that reflect the client's ability to perform self-care tasks essential for sustaining health and safety such as:

(i) bathing,

(ii) eating,

(iii) dressing,

(iv) grooming,

(v) transferring (includes getting in and out of a tub, bed to chair, etc.),

(vi) mobility,

(vii) toileting, and

(viii) bowel/bladder control.

(B) **"ADLs score in high risk range"** means the client's total weighted UCAT ADL score is 10 or more which indicates the client needs some help with 5 ADLs or that the client cannot do 3 ADLs at all plus the client needs some help with 1 other ADL.

(C) **"ADLs score at the high end of the moderate risk range"** means the client's total weighted UCAT ADL score is 8 or 9 which indicates the client needs help with 4 ADLs or that the client cannot do 3 ADLs at all .

(D) **"Client Support high risk"** means the client's UCAT Client Support score is 25 which indicates in the UCAT assessor's clinical judgment that, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, very little or no support is available from informal and formal sources and the client requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

(E) **"Client Support moderate risk"** means the client's UCAT Client Support score is 15 which indicates in the UCAT assessor's clinical judgment, excluding from consideration existing Ryan White CARE Act, Indian Health Service, Medicaid NF, ADvantage and/or State Plan Personal Care services, support from informal and formal sources is available, but overall, it is inadequate, changing, fragile or otherwise problematic and the client requires additional care that is not available through Medicare, Veterans Administration, or other federal entitlement programs.

(F) **"Environment high risk"** means the client's UCAT Environment score is 25 which indicates in the UCAT assessor's clinical judgment, the physical environment is strongly negative or hazardous.

(G) **"Environment moderate risk"** means the client's UCAT Environment score is 15 which indicates in the UCAT assessor's clinical judgment, many aspects of the physical environment are substandard or hazardous.

(H) **"IADL"** means the instrumental activities of daily living.

(I) **"IADLs score in high risk range"** means the client's total weighted UCAT IADL score is 12 or more which indicates the client needs some help with 6 IADLs or cannot do 4 IADLs at all.

(J) **"ICN"** means the client's individual care needs.

(K) **"ICN Score"** means the sum of the MSQ, Health Assessment, Nutrition, ADL and IADL scores.

(L) **"Instrumental activities of daily living"** means those activities that reflect the client's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- (i) shopping,
- (ii) cooking,
- (iii) cleaning,
- (iv) managing money,
- (v) using a telephone,
- (vi) doing laundry,
- (vii) taking medication, and
- (viii) accessing transportation.

(M) **"MSQ"** means the mental status questionnaire.

(N) **"MSQ score in high risk range"** means the client's total weighted UCAT MSQ score is 12 or more which indicates a severe orientation-memory-concentration impairment, or a severe memory impairment.

(O) **"MSQ score at the high end of the moderate risk range"** means the client's total weighted UCAT MSQ score is 10 or 11 which indicates an orientation-memory-concentration impairment, or a significant memory impairment.

(P) **"Nutrition high risk"** means a total weighted UCAT Nutrition score is 12 or more which indicates the client has significant eating difficulties combined with poor appetite, weight loss, and/or special diet requirements.

(Q) **"Social Resources high risk"** means a total weighted UCAT Social Resources score is 15 or more which indicates the client lives alone combined with none or very few social contacts and no supports in times of need.

(2) **Minimum UCAT criteria.** The minimum UCAT criteria for NF

level of care are:

(A) The UCAT documents need for assistance to sustain health and safety as demonstrated by:

(i) either the ADLs or MSQ score is in the high risk range; or,

(ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or,

(II) MSQ score is at the high end of moderate risk range; or,

(III) IADLs score is in the high risk range; or,

(IV) Nutrition score is in the high risk range; or,

(V) Health Assessment is in the moderate risk range, and, in addition,

(B) The UCAT documents absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

(i) Client Support is moderate risk; or,

(ii) Environment is high risk; or,

(iii) Environment is moderate risk and Social Resources is in the high risk range.

(3) **NF Level of Care Services.** To be eligible for NF level of care services, meeting the minimum UCAT criteria demonstrates the individual must:

(A) require a treatment plan involving the planning and administration of services that require skills of licensed technical or professional personnel, are provided directly or under the supervision of such personnel;

(B) have a physical impairment or combination of physical and mental impairments;

**MEDICAL ASSISTANCE FOR ADULTS
AND CHILDREN-ELIGIBILITY**

OAC 317:35-19-7.1 (p5)

(C) require professional nursing supervision (medication, hygiene and/or dietary assistance);

(D) lack the ability to care for self or communicate needs to others;

(E) require medical care and treatment to minimize physical health regression and deterioration;

(F) require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Service; and,

(G) require care that cannot be met through Medicaid state plan services, including Personal Care, if financially eligible.

317:35-19-9. PASRR screening process

(a) Level I screen for PASRR.

(1) OHCA Form LTC-300A, Long Term Care Pre-admission Screen, must be completed by an authorized official of OKDHS, of the nursing facility, of the hospital or a physician. An authorized official is defined as:

(A) A licensed nurse from OKDHS;

(B) The nursing facility administrator or co-administrator;

(C) A licensed nurse from the nursing facility, hospital, or physician's office;

(D) A social service director from the nursing facility or hospital; or

(E) A social worker from the nursing facility or the hospital.

(2) The authorized official as defined in (1) of this subsection must evaluate the properly completed OHCA Form LTC-300A and the Minimum Data Set (MDS), as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), mental retardation (MR), or other related condition, or if such condition existed in the applicant's past history. This evaluation constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the patient to be admitted.

(3) The nursing facility is responsible for determining from the evaluation whether or not the patient can be admitted to the facility. A yes response to any question from the Level I Screen will result in a consultation with LOCEU for the Level II assessment prior to admission.

(4) Upon receipt and review of the medical eligibility information packet, the area nurse re-evaluates whether a Level II PASRR assessment may be required by consultation with LOCEU staff. If a Level II assessment is not required, as determined by LOCEU, the area nurse, or nurse designee, documents this and continues with the process of determining medical eligibility.

If a Level II is required, a medical decision is not made until the area nurse is notified of the outcome of the Level II assessment. The results of the Level II assessment are considered in the medical eligibility decision. The area nurse, or nurse designee, makes the medical eligibility decision within ten working days of receipt of the medical information when a Level II assessment is not required. If a Level II assessment is required, the area nurse makes the decision within five working days if appropriate.

(b) **Pre-admission Level II assessment for PASRR.** The authorized official as defined in (a)(1) of this Section is responsible for consulting with the OHCA LOCEU in determining whether a Level II assessment is necessary. The decision for Level II assessment is made by the LOCEU.

(1) Any one of the following three circumstances will allow a patient to enter the nursing facility without being subjected to a Level II PASRR assessment.

(A) The patient has no current indication of mental illness or mental retardation or other related condition and there is no history of such condition in the patient's past.

(B) The patient does not have a diagnosis of mental retardation or related condition, does not have a primary diagnosis of a major mental illness, and a primary or secondary diagnosis of dementia including dementia of the Alzheimer's type is documented in writing by a physician.

(C) The patient has indications of mental illness or mental retardation or other related condition, but is not a danger to self and/or others, and is being released from an acute care hospital as part of a medically prescribed period of recovery (exempted hospital discharge). If an individual is admitted to an NF based on Exempted Hospital Discharge, it is the responsibility of the NF to ensure that the individual is either discharged by the 30th day or that a Level II has been requested and is in process. Exempted Hospital Discharge is allowed if the following three conditions are met:

(i) The individual must be admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital (not including psychiatric facilities);

(ii) The individual must require NF services for the condition for which he/she received care in the hospital; and

(iii) The attending physician must certify before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(2) If the patient has current indications of mental illness or mental retardation or other related condition, or if there is a history of such condition in the patient's past, the patient cannot be admitted to the nursing facility. Instead, a Level II PASRR assessment must be performed and the results must indicate that nursing facility care is appropriate prior to allowing the patient to be admitted.

(3) The State MR (OKDHS/Developmental Disabilities Services Division) and MI (Department of Mental Health and Substance Abuse Services) authorities have developed advance group determinations by category that take into account certain diagnoses, levels of severity of illness, or need for a particular service which clearly indicate that admission to a NF is normally needed, or that the provision of specialized services (SS) is not normally needed. These determinations are actual Level II decisions and not exemptions from the screening process. For those for whom a categorical determination is made, both the level of care determination and the specialized services determination must be addressed. Only negative categorical specialized services determinations can be made. All positive determinations concerning the need for specialized services must be based on a more extensive individualized evaluation.

(A) The State MI or MR authority may make an advance group determination that NF services are needed in the following categories (after NF receives approval from LOCEU):

(i) **Provisional admission in cases of delirium.** Any person with mental illness, mental retardation or related condition who is not a danger to self and/or others, may be admitted to a Medicaid certified NF if the individual is experiencing a condition that precludes screening, i.e., effects of anesthesia, medication, unfamiliar environment, severity of illness, or electrolyte imbalance.

(I) A Level II evaluation is completed immediately after the delirium clears. LOCEU must be provided with written documentation by a physician that supports the individual's condition which allows provisional admission as defined in (i) of this subparagraph.

(II) Payment for NF services will not be made after the provisional admission ending date. If an individual is determined to need a longer stay, the individual must receive a Level II evaluation before continuation of the stay may be permitted and payment made for days beyond the ending date.

(ii) **Provisional admission in emergency situations.** Any person with a mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility for a period not to exceed seven days pending further assessment in emergency situations requiring protective services. The request for Level II evaluation must be made immediately upon admission to the NF if a longer stay is anticipated. LOCEU must be provided with written documentation from Adult Protective Services or the nursing facility which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(iii) **Respite care admission.** Any person with mental illness, mental retardation or related condition, who is not a danger to self and/or others, may be admitted to a Medicaid certified nursing facility to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay. Respite care may be granted up to 15 consecutive days per stay, not to exceed 30 days per calendar year.

(I) In rare instances, such as illness of the caregiver, an exception may be granted to allow 30 consecutive days of respite care. However, in no instance can respite care exceed 30 days per calendar year.

(II) Respite care must be approved by LOCEU staff prior to the individual's admission to the NF. The NF provides the LOCEU with written documentation

concerning circumstances surrounding the need for respite care, the date the individual wishes to be admitted to the facility, and the date the individual is expected to return to the caregiver. Payment for NF services will not be made after the respite care ending date.

(c) **PASRR Level II resident review.** The resident review is used primarily as a followup to the pre-admission assessment.

(1) The nursing facility's routine resident assessment will identify those individuals previously undiagnosed as MR or MI. A new condition of MR or MI must be referred to LOCEU by the NF for determination of the need for the Level II. The facility's failure to refer such individuals for a Level II assessment may result in recoument of funds and/or penalties from HCFA.

(2) A Level II resident review must be conducted for each resident of a nursing facility who has mental illness or mental retardation or other related condition when there is a significant change in the resident's physical or mental condition.

(3) If such a change should occur in a resident's condition, it is the responsibility of the nursing facility to notify the LOCEU of the need to conduct a resident review.

(4) Individuals who were determined to have a serious mental illness (as defined by HCFA) on their last PASRR Level II evaluation will receive a resident review at least within one year of previous evaluation.

(d) **Results of pre-admission Level II assessment and Resident Review.** Through contractual arrangements between the Oklahoma Health Care Authority and the Mental Illness/Mental Retardation authorities/Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if nursing facility services are needed, if specialized services or lesser than specialized services are needed and what types, and if the individual meets the federal PASRR definition of mental illness or mental retardation or related conditions. Evaluative reports are delivered to the Authority LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to patient, guardian, NF and significant

others.

(e) **Evaluation of pre-admission Level II or Resident Review assessment to determine Medicaid medical eligibility for long term care.** The determination of medical eligibility for care in a nursing facility is made by the area nurse (or nurse designee) unless the individual has mental retardation or related condition or a serious mental illness (as defined by HCFA). The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care patient enters the facility and nursing care is being requested:

(1) The pre-admission screening process must be performed and must allow the patient to be admitted.

(2) The facility will notify the local county office by the OKDHS form ABCDM-83, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Hospice and ABCDM-96 form, Management of Recipient's Funds, of the client admission.

(3) The local county office will send the NF the OKDHS form ABCDM-37D, Notice to Nursing Care Facility or LTCA, indicating actions that are needed or have been taken regarding the client.

317:35-19-18. Change in level of long-term medical care

(a) When a client is receiving Personal Care services and requests nursing facility care or when a client is in a nursing facility and requests Personal Care services, a new UCAT is required. The UCAT is updated if the client is in the nursing facility and requests ADvantage waiver services. No new medical decision is needed. Also, no new medical decision is needed for admission to a nursing facility from home if the period of absence from the nursing facility is less than 90 days. No new medical decision is needed if the client loses financial eligibility but maintains medical eligibility by having a current medical decision and by remaining in the facility during the period of financial ineligibility.

(b) When there is a decision that a client approved for one level of long term care is eligible for a different level of care, the local office is advised by update of the file. If the change is from facility care to Personal Care, a new UCAT, Part III care plan, service plan, and other required forms are submitted to the area nurse, or nurse designee. If the Personal Care recipient requests a decision regarding facility care prior to admission to a facility, the LTC nurse is responsible for submitting the UCAT, Part III, and LTC-300A to the area nurse, or nurse designee for a decision. When the area nurse, or nurse designee, determines that a nursing care recipient no longer needs this level of care, payment may be continued while the recipient, or other responsible person, makes other arrangements. The length of such continuation of payment depends upon the circumstances, but must allow time for the appropriate advance notice to the recipient and cannot exceed 60 days from the date of the decision.

317:35-19-20. Determining financial eligibility of categorically needy individuals

Financial eligibility for NF medical care is determined as follows:

(1) Financial eligibility/categorically related to AFDC.

(A) In determining income for the individual related to AFDC, all family income is considered. The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(i) spouse; and

(ii) parent(s) and minor children of their own.

(I) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule X.

(II) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule I. A.

(B) Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.

(2) Financial eligibility/categorically related to ABD. In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering a nursing facility, see paragraph (2) of OAC 317:35-19-20 to

determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI., is applicable for individuals related to ABD. If the individual is in an NF and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B.1., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard in OKDHS Appendix C-1, Schedule VI., is used.

The rules on determination of income and resources are applicable only when an individual has entered a NF and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends.

(B) An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the recipient and does not affect the vendor payment.

If the institutional stay exceeds the three month period, SSI will make the appropriate change.

(3) Transfer of capital resources on or before August 10, 1993.

Individuals who have transferred capital resources on or before August 10, 1993 and applying for or receiving NF ICF/MR or receiving HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for Medicaid if the individual is eligible at institutionalization. If the individual is not eligible for Medicaid at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for Medicaid. Any subsequent transfer is also subject to this policy. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost (\$2,000) to a private patient in a nursing facility in Oklahoma. The penalty

period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

(A) However, the penalty would not apply if:

(i) The transfer was prior to July 1, 1988.

(ii) The title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.

(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.

(iv) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's resource allowance.

(v) The resource was transferred to the individual's minor child who is blind or totally disabled.

(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.

(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office for

a decision.

(B) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other Medicaid services.

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual.

(D) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored resource or the amount of commensurate return.

(E) The restoration or commensurate return will not entitle the client to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, HCBWS/MR, or ADvantage waiver services for a period of resource ineligibility.

(4) Transfer of assets on or after August 11, 1993. An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 36 months before the first day the individual is both institutionalized and has applied for medical assistance. However, in the case of payments from a trust or portions of a trust that are treated as transfers of assets, the look back date is 60 months.

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an NF.

(C) The penalty period begins the first day of the first month during which assets have been transferred and which does not occur in any other period of ineligibility due to an asset transfer. When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(D) The penalty period consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the asset by the average monthly cost (\$2,000) to a private patient in a nursing facility in Oklahoma. In this calculation, any partial month is dropped. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

(E) Assets are defined as all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action:

(i) by the individual or such individual's spouse;

(ii) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or

(iii) by any person, including any court or administrative body acting at the direction or upon the request of the individual or such individual's spouse.

(F) A penalty would not apply if:

(i) the title to the individual's home was transferred to:

(I) the spouse;

(II) the individual's child under age 21 or who is blind or totally disabled as determined by Social Security;

(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the institutionalization of the individual; or

(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's institutionalization.

(ii) the individual can show satisfactorily that the intent was to dispose of assets at fair market value or that the transfer was exclusively for a purpose other than eligibility. It is presumed that any transfer of assets made for less than fair market value was made in order to qualify the individual for Medicaid. In order to rebut this presumption, the individual must present compelling evidence that a transfer was made for reasons other than to qualify for Medicaid. It is not sufficient for an individual to claim that assets were transferred solely for the purposes of allowing another to have them with ostensibly no thought of Medicaid if the individual qualifies for Medicaid as a result of the transfer.

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance.

(iv) the asset was transferred to the individual's minor child who is blind or totally disabled as determined by Social Security. The transfer may be to a trust established for the benefit of the individual's child.

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value.

(vi) the asset is transferred to a trust established solely for the benefit of a disabled individual under the age of 65.

(vii) the denial would result in undue hardship. Such determination should be referred to OKDHS State Office for a decision.

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other Medicaid services.

(H) The penalty period can be ended by either all assets being restored or commensurate return being made to the

individual.

(I) Once the restoration or commensurate return is made, eligibility is redetermined considering the value of the restored asset or the amount of commensurate return.

(J) The restoration or commensurate return will not entitle the client to benefits for the period of time that the asset remain transferred. An applicant cannot be certified for nursing care services for a period of asset ineligibility.

(K) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated shall be considered a transfer.

(L) When a transfer of assets by the spouse of an individual results in a period of ineligibility and the spouse who made such transfer subsequently becomes institutionalized, the period of ineligibility will be apportioned between the two institutionalized spouses.

(5) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the client's behalf; i.e., property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

317:35-19-22. Certification for NF

(a) **Application date.** The date of the application for NF care is most important in determining the date of eligibility. If the applicant is found eligible for Medicaid, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months.

(1) As soon as eligibility or ineligibility for long-term medical care is established the local office updates the computer form and the appropriate notice is computer generated to the client and vendor. Notice information is retained on the notice file for county use.

(2) An applicant approved for long-term medical care under Medicaid as categorically needy is mailed a Medical Identification Card.

(3) When eligibility is established for care in an NF, the certification is not teleprocessed until the Management of Recipient's Funds form has been received from the administrator of the facility providing the care.

(b) **Time limited approvals for nursing care.** A medical certification period of a specific length may be assigned for an individual who is categorically related to ABD or AFDC. This time limit is noted on the system. It is the responsibility of the nursing facility to notify the area nurse 30 days prior to the end of the certification period if an extension of approval is required by the client. Based on the information from the NF the area nurse, or nurse designee, determines whether or not an update of the UCAT is necessary for the extension. The area nurse, or nurse designee, coordinates with appropriate staff for any request for further UCAT assessments.

(c) **Certification period for long-term medical care.** A financial certification period of 12 months is assigned for an individual categorically related to ABD who is approved for long-term care. When the individual determined eligible for long-term medical care is categorically related to AFDC, a certification period of six months is assigned. Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.