Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: January 6, 2025

The proposed policy is a Permanent Rule. The proposed policy was presented at the November 5, 2024 Tribal Consultation. Additionally, this proposal will be presented at a Public Hearing scheduled for January 6, 2025 and is scheduled to be presented to the Medical Advisory Committee on January 9, 2025 and the OHCA Board of Directors on January 15, 2025

SUMMARY: OHCA will update its policy to remove outdated and inappropriate language. Specifically, references to "mentally retarded" and "mental retardation" will be replaced with the more respectful term "individuals with intellectual disabilities" or "intellectual disability." This update aims to ensure that the language in policy reflects current terminology, promoting dignity and inclusivity.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; 20 CFR Parts 404 & 416; and Sections 25-40 of Title 25 Oklahoma Statute

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 24-31B

A. Brief description of the purpose of the rule:

The proposed policy revisions will update OHCA policy to remove outdated and inappropriate language. Specifically, references to "mentally retarded" and "mental retardation" will be replaced with the more respectful term "individuals with intellectual disabilities" or "intellectual disability." This update aims to ensure that the language in policy reflects current terminology, promoting dignity and inclusivity.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

The proposed rule changes will affect SoonerCare members and their families as these proposed revisions will create a more respectful environment when interacting with healthcare

providers and accessing services. This rule change should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit SoonerCare members and their families as this change reflects a commitment to using language that respects all individulas. The proposed rule changes have the potential to improve access to care and health equity.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes are budget neutral.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule changes.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and

environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no adverse effect on the public health, safety or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health and safety if the proposed rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared date: November 21, 2024

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELGIBILITY AND COUNTABLE INCOME

PART 3. NONMEDICAL ELIGIBILTY REQUIREMENTS

317:35-5-26. Residence requirements; residents of public institutions; homeless persons; and residents of IHS, BIA or Tribal controlled dormitories

(a) **Residence.** To be eligible for SoonerCare services, the applicant must be residing in the State of Oklahoma with intent to remain at the time the medical service is received. A durational residence requirement is not imposed.

(1) Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

(2) Oklahoma residence does not include transients or visitors passing through the state but does not preclude persons who do not have a fixed address if intent is established.

(3) Intent to remain or return is defined as a clear statement of plans to remain or return in addition to other evidence and/or corroborative statements of others.

(4) When a non-resident makes application for SoonerCare benefits, the local office provides services necessary to make available to the applicant any SoonerCare services for which he/she might be eligible from his/her state of residence. The local office contacts the state or county of the applicant's residence to explore possible eligibility for medical benefits from the state and to obtain information needed for the determination of medical eligibility for the services received while in Oklahoma.

(5) If a member's whereabouts are unknown, as indicated by the return of unforwardable agency mail, refer to OAC 317:35-5-67.

(b) **Individuals residing in institutions (correctional facilities and institutions for mental**

disease). The SoonerCare program will only pay for services rendered to adults (21 through 64 years of age) who are inpatients in an institution for mental disease (IMD), juveniles in the custody of the Office of Juvenile Affairs who are inmates in a state-owned and operated facility, or inmates in a correctional facility, when these individuals are admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities and meet all other eligibility requirements.
(c) **Homeless individuals.** Individuals are not required to have a fixed address in order to be eligible for assistance. Individuals who lack a fixed or regular residence, who have temporary accommodations, i.e., supervised shelters, residence of other individuals, a hallway, bus station, car or other similar places, are considered as "homeless".
(d) **Individuals residing in IHS, BIA or Tribal controlled dormitories.** Individuals that reside in a facility which provides students boarding and lodging on a temporary residential basis for the purpose of attending a Bureau-operated or Indian-controlled contract or public school are considered Oklahoma residents for SoonerCare eligibility purposes.

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 1. SERVICES

317:35-9-1. Overview of long-term medical care services; relationship to QMB, SLMB, and other Medicaid services eligibility, and spenddown calculation

(a) **Long Term Medical Care Services**. Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities (refer to this subchapter), persons age 65 years or older in mental health hospitals (refer to this subchapter), Home and Community Based Waiver Services for the Intellectually Disabled (refer to this subchapter), and Home and Community Based Waiver Services for frail elderly and a targeted group of adults with physical disabilities age 21 and over who have not been determined to have a developmental disability, an intellectual disability or a related condition (refer to OAC 317:35-17). Personal Care provides services in the own home for categorically needy individuals (refer to OAC 317:35-15). Any time an individual is certified as eligible for Medicaid coverage of long-term care, the individual is also eligible for other Medicaid services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB or SLMB coverage.
(b) **Medicaid recovery.** The State of Oklahoma operates a Medicaid Recovery program to recover for services identified in OAC 317:35-9-15. Recovery can be accomplished in two ways: liens against real property or claims made against estates.

317:35-9-5. Home and Community - Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) Home and Community Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions are operated by the Oklahoma Department

of Human Services (OKDHS) Developmental Disabilities Services Division (DDSD) per OAC 317:40-1-1. Oklahoma's Medicaid agency, the Oklahoma Health Care Authority (OHCA), provides oversight of Waiver operation. HCBS Waivers allow the OHCA to offer certain home and community based services to categorically needy members who, without such services, would be eligible for care in an Intermediate Care Facility for persons with ~~Mental Retardation~~an Intellectual Disability (ICF/~~MR~~IID).

(b) Members receiving HCBS Waiver services per OAC 317:40-1-1 are subject to HCBS Waiver service conditions (1)-(11) of this subsection. The rules in this subsection shall not be construed as a limitation of the rights of class members set forth in the Second Amended Permanent Injunction in Homeward Bound vs. The Hissom Memorial Center.

(1) HCBS Waiver services are subject to annual appropriations by the Oklahoma Legislature.

(2) DDSD must limit the utilization of the HCBS Waiver services based on:

(A) the federally-approved member capacity for the individual HCBS Waivers; and

(B) the cost effectiveness of the individual HCBS Waivers as determined according to federal requirements; and

(3) DDSD must limit enrollment when utilization of services under the HCBS Waiver programs is projected to exceed the spending authority.

(4) Members receiving Waiver services must have full access to State plan services for which they are eligible including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when children participate in a Waiver.

(5) A member's room and board expenses may not be paid through a Waiver. Room and board expenses must be met from member resources or through other sources.

(6) A member must require at least one Waiver service per month or monthly case management monitoring in order to function in the community.

(7) Waiver services required by a member must be documented in advance of service delivery in a written plan of care.

(8) Members exercise freedom of choice by choosing Waiver services instead of institutional services.

(9) Members have the right to freely select from among any willing and qualified provider of Waiver services.

(10) The average costs of providing Waiver and non-Waiver SoonerCare services must be no more costly than the average costs of furnishing institutional (and other SoonerCare state plan) services to persons who require the same level of care.

(11) Members approved for services provided in a specific Waiver must be afforded access to all necessary services offered in the specific Waiver if the member requires the service.

PART 2. MEDICAID RECOVERY PROGRAM

317:35-9-15. Medicaid recovery

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the State to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority (OHCA) on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities or other medical institution creates a debt to the OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a

claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this Part. Recovery for payments made under Title XIX for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include:

(1) nursing facility services;
(2) home and community based services;
(3) related hospital services;
(4) prescription drug services;
(5) physician services; and
(6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice and opportunity for a hearing, against the real property of a member who is an inpatient in a nursing facility, ICF/~~MR~~IID or other medical institution in certain instances.

(1) **Exceptions to filing a lien**.

(A) A lien may not be filed on the home property if the member's family includes:

(i) a surviving spouse residing in the home;
(ii) a child or children age 20 or less lawfully residing in the home ;
(iii) a disabled child or children of any age lawfully residing in the home; or
(iv) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(B) If an individual covered under an Oklahoma Long-term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual for the amount of assets or resources disregarded.

(2) **Reasonable expectation to return home**. A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least 90 days. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination

has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

(3) **Undue hardship waiver**. When enforcing a lien or a recovery from an estate [see (c) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, when the individual or his/her family is merely inconvenienced or when their lifestyle is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted. If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.

(4) **Filing the lien**. After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of an intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative. The lien must contain the following information:

(A) the name and mailing address of the member, spouse, legal guardian, authorized representative, or individual acting on behalf of the member;

(B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for Title XIX on the member's behalf;

(C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities or other medical institution;

(D) the legal description of the real property against which the lien will be recorded; and

(E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien**. The lien filed by OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

(A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;

(B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;

(C) when there is no adult child of the member, natural or adopted, who is blind or disabled, as defined in OAC 317:35-1-2, residing in the home;

(D) when no brother or sister of the member is lawfully residing in the home, who has

resided there for at least one year immediately before the date of the member's admission to the nursing facility, and has resided there on a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien**. The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is attached, for a period of more than 90 days without being re-admitted to a facility providing nursing care, even though there may have been no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources**. Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery from estates**.

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.

(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.

(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.

(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.

(5) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual's estate for the amount of assets or resources disregarded.

PART 3. APPLICATION PROCEDURES

317:35-9-25. Application for ~~ICF/MR~~ICF/IID, HCBW/ID, and persons aged 65 or over in mental health hospitals.

(a) **Application procedures for long-term medical care**. An application for these types of services consists of the Medical Assistance Application. The Medical Assistance Application is signed by the patient, parent, spouse, guardian or someone else acting on the patient's behalf.

(1) All conditions of eligibility must be verified and documented in the case record. When current information already available in the local office establishes 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.

(2) At the request of an individual in an ~~ICF/MR~~ICF/IID or receiving Home and Community Based Waiver Services for the Intellectually Disabled or the community spouse, if application for Medicaid is not being made, an assessment of the resources available to each spouse is made by use of DHS Form MA-11, Assessment of Assets. Documentation of resources must be provided by the individual and/or spouse. This 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 eligibility is made. A copy of Form MA-11 is provided to each spouse for planning in regard to future eligibility. A copy is retained in the county office in case of subsequent application.

(3) If assessment by Form MA-11 was not done at the time of entry into the ~~ICF/MR~~ICF/IID or HCBW/ID services, assessment by use of Form MA-11 must be done at the time of application for Medicaid. The spousal share of resources is determined in either instance for the month of entry into the ~~ICF/MR~~ICF/IID or HCBW/ID services. If the individual applies for Medicaid at the time of entry into the ~~ICF/MR~~ICF/IID or HCBW/ID services, 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 DHS Form MA-12, Title XIX Worksheet.

(b) **Date of application**. When application is made in the county office the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application is stamped into the county office. When a request for Medicaid is first made by an oral request, and the application form is signed later, the date of the oral request is entered in "red" above the date the form is signed. The date of the oral request is the date of application.

317:35-9-26. Application procedures for private ICF/~~MR~~IID

Individuals may apply for private ~~ICF/MR~~ICF/IID at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active SoonerCare case. The OKDHS Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice form 08MA083E, when received in the HSC, also constitutes an application request and is handled the same as an oral request. The local HSC will send the ~~ICF/MR~~ICF/IID OKDHS form 08MA038E within three working days of receipt of OKDHS forms 08MA083E and 08MA084E, Management of Recipient's Funds, indicating actions that are needed or have been taken regarding the member.

317:35-9-27. Application procedures for public ~~ICF/MR~~ICF/IID

When an individual is admitted to a public ~~ICF/MR~~ICF/IID, an application for payment of long-term care in the facility is made at the time of admission. A designated worker from the county office in the county where the facility is located assists in this part of the admission process. The superintendent of the facility may sign the application on behalf of the individual if the responsible parent or guardian is not available. A case record is set up, in the county where the facility is located, for each applicant of the public ~~ICF/MR~~ICF/IID. If the individual leaves the facility, the county case is transferred, if necessary, to the county of residence

PART 11. PAYMENT, BILLING, AND OTHER ADMINSTRATIVE PROCEDURES

317:35-9-103. Special procedures for release of adults in mental health hospitals to long-term care facilities

(a) **Procedures**. Adult patients in state mental health hospitals being considered for release to long-term care facilities due to their physical conditions may be predetermined eligible for Medicaid.

(b) **Responsibility of mental health hospitals**. The mental health hospital social and reimbursement staff works with the Social Security Administration to secure the approval for Supplemental Security Income (SSI) for individuals not currently eligible who may qualify for SSI. They will also assist the patient with the application for Medicaid medical services. By forwarding the completed Medical Assistance Application form and the Capital Resources Information form to the county office, the determination of financial eligibility by the DHS county worker can proceed at the same time that SSA is determining SSI eligibility. If the individual has other income (Social Security, VA, etc.) and does not qualify for SSI, the mental health hospital social and reimbursement staff evaluates the known resources. If the resources do not exceed the maximum as shown on the DHS Appendix C-1, Schedule VIII. D., individuals may be referred for a decision of eligibility for care in an intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities and, if necessary, categorical relationship. If the individual appears to meet the requirements as set out in this Subchapter, the mental health hospital social and reimbursement staff will submit a copy of the admitting history and physical progress notes, psychiatric examination and a physician's recommendation for a specific level of care, based on the individual's physical condition, to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division for review. If release to a long-term care facility appears appropriate, the medical information is submitted to LOCEU at the same time that the application forms are submitted to the county.

(c) **Responsibility of LOCEU**. The LOCEU reviews the hospital records, the social summary, the physician's recommendation for level of care as well as categorical relationship, if necessary. A Level II PASRR assessment is initiated by LOCEU at this point, if indicated. The MEDATS file is updated advising the DHS county office of LOCEU's decision.

(d) **Responsibility of the DHS county office**. The county office (in the county where the hospital is located) has the responsibility for the case number assignment, placing the case in application status and the subsequent determination of financial eligibility. The case is not certified until the patient enters an approved long-term care facility.

(1) Once the patient is determined financially and medically eligible a letter (including the assigned case number) is sent to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division.

(2) If the patient is determined to be ineligible, the denial is teleprocessed and a computer generated notice sent to the client or responsible person.

(e) **Release from mental health hospital to a long-term care facility**. After the hospital receives the letter from the county office with anticipated approval for Medicaid, the arrangements for release to the long-term care facility will proceed. The hospital will supply the long-term care facility with appropriate medical and social information and a copy of the DHS letter concerning the financial and medical eligibility.

(1) The long-term care facility, upon acceptance of the patient, forwards DHS form ABCDM-83, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice (with the assigned case number) to the DHS county office where the long-term care facility is located.

(2) If the long-term care facility is in a different county than the hospital, the county of the facility requests the transfer of the case record. The certification is teleprocessed prior to the transfer of the case record.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-6. Application procedures for NF

Individuals may apply for nursing home care at the OKDHS human services center (HSC) of their choice. A written application is not required for an individual who has an active SoonerCare case. For NF, OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice form, when received in the HSC, also constitutes an application request and is handled the same as an oral request.

317:35-19-9. PASRR screening process

(a) **Level I screen for PASRR.**

(1) OHCA Form LTC-300R, Nursing Facility Level of Care Assessment, must be completed by an authorized NF official or designee. An authorized NF official or designee must consist of one of the following:

(A) The NF administrator or co-administrator;

(B) A licensed nurse, social service director, or social worker from the facility; or

(C) A licensed nurse, social service director, or social worker from the hospital.

(2) Prior to admission, the authorized NF official must evaluate the properly completed OHCA Form LTC-300R and the Minimum Data Set (MDS), if available, as well as all other readily available medical and social information, to determine if there currently exists any indication of mental illness (MI), intellectual disability (ID), or other related condition, or if such condition existed in the applicant's past history. Form LTC-300R constitutes the Level I PASRR Screen and is utilized in determining whether or not a Level II is necessary prior to allowing the member to be admitted.

(3) The NF is responsible for determining from the evaluation whether or not the member can be admitted to the facility. A "yes" response to any question from Form LTC-300R, Section E, will require the NF to contact the Level of Care Evaluation Unit (LOCEU) for a consultation to determine if a Level II assessment is needed. The facility is also responsible

for consulting with the LOCEU regarding any mental illness, an intellectual disability, or related condition information that becomes known either from completion of the MDS or throughout the resident's stay. The original Form LTC-300R must be submitted to the LOCEU by mail within ten (10) days of the resident's admission. SoonerCare payment may not be made for a resident whose LTC-300R requirements have not been satisfied in a timely manner.

(4) Upon receipt and review of the PASRR eligibility information packet, the LOCEU may, in coordination with the Oklahoma Department of Human Services (OKHDS) area nurse, re-evaluate whether a Level II PASRR assessment may be required. If a Level II assessment is not required, as determined by the 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 (10) 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 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 (3) circumstances will allow a member to enter the NF without being subjected to a Level II PASRR assessment:

(A) The member has no current indication of mental illness or an intellectual disability or other related condition and there is no history of such condition in the member's past;

(B) The member does not have a diagnosis of an intellectual disability or related condition; or

(C) The member has indications of mental illness or an intellectual disability 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 only if all of the following three (3) 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 thirty (30) days of nursing facility services. The NF will be required to furnish documentation to the OHCA upon request.

(2) If the member has current indications of mental illness or an intellectual disability or other related condition, or if there is a history of such condition in the member's past, the member cannot be admitted to the NF until the LOCEU is contacted to determine if a Level II PASRR assessment must be performed. Results of any Level II PASRR assessment ordered must indicate that NF care is appropriate prior to allowing the member to be admitted.

(3) The OHCA Level of Care Evaluation Unit authorizes Advance Group Determinations for the MI and ID Authorities in the categories listed in the following categories listed in (A) through (C) of this paragraph. Preliminary screening by the LOCEU should indicate eligibility for NF level of care prior to consideration of the provisional admission.

(A) **Provisional admission in cases of delirium.** Any person with mental illness, an intellectual disability or related condition who is not a danger to self and/or others, may be admitted to a Title XIX 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.

(B) **Provisional admission in emergency situations.** Any person with a mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF 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 facility which supports the individual's emergency admission. Payment for NF services will not be made beyond the emergency admission ending date.

(C) **Respite care admission.** Any person with mental illness, an intellectual disability or related condition, who is not a danger to self and/or others, may be admitted to a Title XIX certified NF 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 fifteen (15) consecutive days per stay, not to exceed thirty (30) days per calendar year.

(i) In rare instances, such as illness of the caregiver, an exception may be granted to allow thirty (30) consecutive days of respite care. However, in no instance can respite care exceed thirty (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 follow-up to the pre-admission assessment.

(1) The facility's routine resident assessment will identify those individuals previously undiagnosed as intellectually disabled or mentally ill. A new condition of intellectual disabilities or mental illness 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 recoupment of funds and/or penalties from CMS.

(2) A Level II resident review may be conducted the following year for each resident of a NF who was found to experience a serious mental illness with no primary diagnosis of dementia on his or her pre-admission Level II to determine whether, because of the resident's physical and mental condition, the resident requires specialized services.

(3) A Level II resident review may be conducted for each resident of a NF who has mental illness or an intellectual disability or other related condition when there is a significant change in the resident's mental condition. If such a change should occur in a resident's condition, it is the responsibility of the facility to have a consultation with the LOCEU concerning the need to conduct a resident review.

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

(d) **Results of pre-admission Level II assessment and Resident Review.** Through contractual arrangements between the OHCA and the Mental Illness/Intellectual Disabilities Authorities/ Community Mental Health Centers, individualized assessments are conducted and findings presented in written evaluative reports. The reports recommend if NF services are needed, if specialized services or less than specialized services are needed, and if the individual meets the federal PASRR definition of mental illness or intellectual disability or related conditions. Evaluative reports are delivered to the OHCA's LOCEU within federal regulatory and state contractual timelines to allow the LOCEU to process formal, written notification to member, 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 NF is made by the area nurse (or nurse designee) unless the individual has an intellectual disability or related condition or a serious mental illness. The procedures for obtaining and submitting information required for a decision are outlined in this subsection. When an active long term care member enters the facility and nursing care is being requested:

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

(2) The facility will notify the local county office by the OKDHS Form 08MA083E, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice and Form 08MA084E, Management of Recipient's Funds, of the member's admission.

(3) The local county office will send the NF the OKDHS Form 08MA038E, Notice Regarding Financial Eligibility, indicating actions that are needed or have been taken regarding the member.

317:35-19-31. Special procedures for release of adults in mental health hospitals to Nursing Facilities

(a) **Procedures**. Adult patients in state mental health hospitals being considered for release to nursing facilities due to their physical conditions may be predetermined eligible for Medicaid.

(b) **Responsibility of mental hospitals**. The mental health hospital social and reimbursement staff works with the Social Security Administration to secure the approval for Supplemental Security Income (SSI) for individuals not currently eligible who may qualify for SSI. They will also assist the patient with the application for Medicaid medical services. By forwarding the completed Medical Assistance Application form and the Capital Resources Information form to

the county office, the determination of financial eligibility by the DHS county social worker can proceed at the same time that SSA is determining SSI eligibility. If the individual has other income (Social Security, VA, etc.) and does not qualify for SSI, the mental health hospital social and reimbursement staff evaluates the known resources. If the resources do not exceed the maximum as shown on DHS Appendix C-1, Schedule VIII. D., individuals may be referred for a decision of eligibility for care in a nursing facility and, if necessary, categorical relationship. If the individual appears to meet the requirements as set out in this Subchapter, the mental health hospital social and reimbursement staff will submit a copy of the admitting history and physical progress notes, psychiatric examination and a physician's recommendation for a specific level of care, based on the individual's physical condition, to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division for review. If release to an NF appears appropriate, the medical information is submitted to LOCEU at the same time that the application forms are submitted to the county.

(c) **Responsibility of LOCEU.** The LOCEU reviews the hospital records, the social summary, the physician's recommendation for level of care as well as categorical relationship, if necessary. A Level II PASRR screen is initiated by LOCEU at this point, if indicated. The MEDATS file is updated advising the DHS county office of LOCEU decision.

(d) **Responsibility of county office**. The county office (in the county where the hospital is located) has the responsibility for the case number assignment, placing the case in application status and the subsequent determination of financial eligibility. The case is not certified until the patient enters an approved nursing facility.

(1) Once the patient is determined financially and medically eligible a letter (including the assigned case number) is sent to the Department of Mental Health and Substance Abuse Services, Central Office, Long-Term Care Division.

(2) If the patient is determined to be ineligible, the denial is teleprocessed and a computer generated notice sent to the client or responsible person.

(e) **Release from mental health hospital to an NF**. After the hospital receives the letter from the county office with anticipated approval for Medicaid, the arrangements for release to the nursing facility will proceed. The hospital will supply the NF with appropriate medical and social information and a copy of the DHS letter concerning the financial and medical eligibility.

(1) The NF, upon acceptance of the patient, forwards the DHS form ABCDM-83, Notification Regarding Patient in a Nursing Facility, Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities or Hospice (with the assigned case number) to the DHS county office where the NF is located.

(2) If the NF is in a different county than the hospital, the county of the facility requests the transfer of the case record. The certification is teleprocessed prior to the transfer of the case record.