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 16, 2019

The proposed policy is a Permanent Rule. The proposed policy was presented at the November 6, 2018 Tribal Consultation. Additionally, this proposed change will be presented at a Public Hearing scheduled for January 16, 2019. This proposal is scheduled to be presented to the Medical Advisory Committee on January 17, 2019 and to the OHCA Board of Directors on February 14, 2019.

Reference: APA WF # 18-21B

SUMMARY:
ADvantage Waiver Revisions – Proposed revisions to the ADvantage Waiver will add new language to outline requirements for personal care services and consumer directed personal assistance services and supports (CD-PASS) for case management services. Revisions will also remove and update outdated policy in order to align with current business practices, and ensure rules are in accordance with state laws and regulations.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (F)(1) and (3) of Title 63 of Oklahoma Statutes; Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Director of Human Services; Section 162 of Title 56 of the Oklahoma Statutes; Title 42 of the Code of Federal Regulations, Parts 430 and 431.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Ivoria Holt
Federal and State Policy

FROM: Carmen Johnson
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 18-21B

A. Brief description of the purpose of the rule:

The proposed revisions amend language to remove outdated language regarding the Uniform Comprehensive Assessment Tool (UCAT) Part III submission and align it with the ADvantage eligibility policy. Additional revisions will add guidelines for the Department of Human Services (DHS) nurse when establishing/assigning a medical certification period, with annual reviews, for persons younger than eighteen (18) years of age. Further revisions address personal care services medical eligibility extensions when medical redetermination is not made by current medical certification end date; what constitutes reasons that personal care services may be terminated in a member's home and documentation that must be provided to justify termination. Other revisions will provide clarification on service provider's and service recipient's duties and responsibilities reflect new federal regulations that affect the Electronic Visit Verification (EVV) process and implementation and process changes for case management services. Finally, rules will add language to clarify existing policy procedure and practice in administering Consumer-Directed Personal Assistance Services and Supports (CD-PASS) service options.

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 classes of persons affected by the proposed revisions are DHS Aging Services, ADvantage Waiver services and State Plan personal care services providers, which bear no costs associated with the implementation of the rules.

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

The proposed rule will benefit individuals receiving DHSw Aging Services, ADvantage Waiver Services and State Plan personal care services.

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 on individuals who receive DHS Aging Services or ADvantage Waiver services.

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 effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The probable cost to DHS includes the cost of printing and distributing the rules, estimated to be less than $20.

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 does not have an impact on any political subdivisions or require their cooperation in enforcing the rules.

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 proposed rule does not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

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 proposed rule will not increase compliance costs. There are no less costly or non-regulatory methods or less intrusive methods.

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 will clarify the medical eligibility processes and services for ADvantage and State Plan personal care programs, thereby increasing program effectiveness, positively impacting the health, safety and well-being of affected persons.

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

If the proposed rules are not implemented, the rules will not provide clarification of ADvantage Waiver services and State Plan personal care services and increase the costs of services provided. This could allow for ongoing eligibility for SoonerCare (Medicaid) services for those who are eligible.

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

Prepared: October 26, 2018
Modified: December 4, 2018

REGULATORY TEXT:

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

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-4. Determination of medical eligibility for Personal Care

(a) **Eligibility.** The Oklahoma Department of Human Services (DHS) area nurse determines medical eligibility for personal care services based on the Uniform Comprehensive Assessment Tool (UCAT) Part III and the determination that the member has unmet care needs that require personal care services. Personal care services are initiated to support the ~~informal~~regular care provided in the member's home. Personal care services are not intended to take the place of regular care and general maintenance tasks or meal preparation shared or done for one another by natural supports, such as spouses or other adults who live in the same household. Additionally, personal care services are not furnished when they principally benefit the family unit. To be eligible for personal care services, the individual must:

(1) have adequate informal supports consisting of adult

supervision that is present or available to contribute to care, or decision-making ability as documented on the UCAT~~,~~ Part III, to remain in his or her home without risk to his or her health, safety, and well-being, the individual:

(A) must have the decision-making ability to respond appropriately to situations that jeopardize his or her health and safety or available supports that compensate for his or her lack of ability as documented on the UCAT~~;~~ Part III; or

(B) who has his or her decision-making ability, but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and was informed by the DHS nurse of potential risks and consequences, may be eligible~~;~~.

(2) require a plan of care involving the planning and administration of services delivered under the supervision of professional personnel;

(3) have a physical impairment or combination of physical and mental impairments as documented on the UCAT~~.~~ Part III. An individual who poses a threat to self or others as supported by professional documentation or other credible documentation may not be approved for Personal Care services. An individual who is actively psychotic or believed to be in danger of potential harm to self or others may not be approved for personal care services;

(4) not have members of the household or persons who routinely visit the household who, as supported by professional documentation or other credible documentation, pose a threat of harm or injury to the individual or other household visitors;

(5) lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

(6) require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.ww

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

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

(A) bathing;

(B) eating;

(C) dressing;

(D) grooming;

(E) transferring~~,~~ includes activities~~,~~ such as getting in and out of a tub~~,~~ or bed to chair;
(F) mobility;
(G) toileting; and
(H) bowel/bladder control.

(2) **"ADLs score of three or greater"** means the member cannot do at least one ADL at all or needs some help with two or more ADLs.

(3) **"Consumer support very low need"** means the member's UCAT Part III Consumer Support score is zero (0) ~~that~~which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal sources are sufficient for present level of member need in most functional areas.

(4) **"Consumer support low need"** means the member's UCAT Part III Consumer Support score is five (5) ~~that~~which indicates, in the UCAT Part III assessor's clinical judgment, the support from formal and informal sources are nearly sufficient for present level of member need in most functional areas. The member, family, or informal supports are meeting most needs typically expected of family or household members to share or do for one another, such as general household maintenance. There is little risk of institutional placement with loss of current supports.

(5) **"Consumer support moderate need"** means the UCAT Part III Consumer score is ~~15~~fifteen (15) ~~that~~which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal support is available, but overall, it is inadequate, changing, fragile, or otherwise problematic. The member requires additional assistance that usually includes personal care assistance with one or more ADLs not available through Medicare, the Veterans Administration, or other federal entitlement programs. Support provided by informal caregivers is of questionable reliability due to one (1) or more of the following:
(A) care or support is required continuously with no relief or backup available;
(B) informal support lacks continuity due to conflicting responsibilities~~,~~ such as work or child care;
(C) care or support is provided by persons with advanced age or disability; or
(D) institutional placement can reasonably be expected with any loss of existing support.

(6) **"Consumer support high need"** means the member's UCAT Part III Consumer score is ~~25~~twenty-five (25) ~~that~~which indicates, in the UCAT Part III assessor's clinical judgment, the formal and informal supports are not sufficient as there is very little or no support available to meet a high degree of member need.

(7) **"Community services worker"** means any non-licensed health professional employed by or under contract with a community services provider who provides, for compensation or as a volunteer, health-related services, training, or supportive assistance to frail elderly, disabled person(s), or person(s) with developmental disabilities.
(8) **"Community Services Worker Registry"** means a registry established by the DHS, per Section (§) 1025.1 ~~et seq.~~ of Title 56 of the Oklahoma Statutes~~,~~ (O.S.) to list community services workers against whom a final investigative finding of abuse, neglect, or exploitation, per ~~Section 10-103 of Title 43A of the Oklahoma Statutes,~~43A O.S. § 10-103, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities was made by DHS or an administrative law judge~~,~~; and amended in 2002, to include the listing of SoonerCare (Medicaid) personal care assistants (PCAs) providing personal care services.
(9) **"Instrumental activities of daily living (IADL)"** means those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety, such as:
(A) shopping;
(B) cooking;
(C) cleaning;
(D) managing money;
(E) using a ~~telephone;~~phone;
(F) doing laundry;
(G) taking medication; and
(H) accessing transportation.
(10) **"IADLs score is at least six" (6)"** means the member needs some help with at least three (3) IADLs or cannot do two (2) IADLs at all.
(11) **"IADLs score of eight (8) or greater"** means the member needs some help with at least four (4) IADLs or the member cannot do two (2) IADLs at all and needs some help with one (1) or more other IADLs.
(12) **"MSQ"** means the mental status questionnaire.
(13) **"MSQ moderate risk range"** means a total weighted-score of seven (7) to ~~11~~eleven (11) that indicates an orientation-memory-concentration impairment or memory impairment.
(14) **"Nutrition moderate risk"** means the total weighted UCAT Part III Nutrition score is eight (8) or more that indicates poor appetite or weight loss combined with special diet requirements, medications, or difficulties in eating.
(15) **"Social resources score is eight (8) or more"** means the member lives alone or has no informal support when he or she is sick, needs assistance, or has little or no contact with others.

(c) **Medical eligibility minimum criteria for personal care.** The medical eligibility minimum criteria for personal care are the minimum UCAT Part III score criteria that a member must meet for medical eligibility for personal care and are:

(1) ADLs score is five (5) or greater; or IADLs score of eight (8) or greater; or Nutrition score is eight (8) or greater; or the MSQ score is seven (7) or greater; or the ADLs score is three (3) and IADLs score is at least six~~;~~ (6); and

(2) Consumer Support is ~~15~~fifteen (15) or more; or Consumer Support score is five (5) and the Social Resources score is eight or more.

(d) **Medical eligibility determination.** Medical eligibility for personal care is determined by the DHS. The medical decision for personal care is made by the DHS area nurse utilizing the UCAT~~.~~ Part III.

(1) Categorical relationship must be established for determination of eligibility for personal care. When categorical relationship to Aid to the Disabled was not established but there is an extremely emergent need for personal care, and current medical information is not available, the local office authorizes a medical examination. When authorization is necessary, the county director issues Form 08MA016E, Authorization for Examination, and Form 08MA02E, Report of Physician's Examination, to a licensed medical or osteopathic health care professional, refer to Oklahoma Administrative Code (OAC) 317:30-5-1. The licensed health care professional cannot be in a medical facility internship, residency, or fellowship program or in the full time employment of the Veterans Administration, United States Public Health Service, or other agency. The DHS county worker submits the information to the Level of Care Evaluation Unit (LOCEU) to request a determination of eligibility for categorical relationship. LOCEU renders a decision on the categorical relationship using the Social Security Administration (SSA) definition. A follow-up is required by the DHS county worker with (SSA) to ensure the SSA disability decision is also the LOCEU decision.

(2) Approved contract agencies or the ADvantage Administration (AA) may complete UCAT Part I for intake and screening and forward the form to the county office.

(3) Upon receipt of the referral, DHS county staff may initiate the UCAT, Part I.

(4) The DHS nurse is responsible for completing the UCAT Part III assessment visit within ~~10-business~~ten (10)-business days of the personal care referral for the applicant who is SoonerCare eligible at the time of the request. The DHS nurse completes the assessment visit within ~~20-business~~twenty (20)-

business days of the referral for the applicant not determined SoonerCare eligible at the time of the request. When the UCAT Part I indicates the request is from an individual who resides at home and an immediate response is required to ensure the health and safety of the person, emergency situation, or to avoid institutional placement, the UCAT Part III assessment visit has top-scheduling priority.

(5) During the assessment visit, the DHS nurse completes the UCAT Part III and reviews rights to privacy, fair hearing, provider choice, and the pre-service acknowledgement agreement with the member. The DHS nurse informs the applicant of medical eligibility criteria and provides information about DHS long-term care service options. The DHS nurse documents if the member wants to be considered for nursing facility level of care services or if the member is applying for a specific service program on UCAT Part III. When, based on the information obtained during the assessment, the DHS nurse determines if the member may be at risk for health and safety, an immediate referral is made to Adult Protective Services (APS) or Child Protective Services, as applicable. The referral is documented on the UCAT~~.~~ Part III.

(A) When the applicant's needs cannot be met by personal care services alone, the DHS nurse informs the applicant of the other community long-term care service options. The DHS nurse assists the applicant in ~~access~~accessing service options selected by the applicant in addition to, or in place of, Personal Care services.

(B) When multiple household members are applying for SoonerCare ~~Personal Care~~personal care services, the UCAT Part III assessment is done for all the household members at the same time.

(C) The DHS nurse informs the applicant of the qualified agencies in his or her local area that provide services and obtains the applicant's primary and secondary choice of agencies. When the applicant or family declines to choose a primary personal care service agency, the DHS nurse selects an agency from a list of all available agencies, using a round-robin system. The DHS nurse documents the name of the selected personal care provider agency.

(6) The DHS nurse completes the UCAT ~~within three-business days of the assessment visit~~Part III and sends it to the DHS area nurse for medical eligibility determination. Personal care service eligibility is established on the date medical eligibility is approved and financial eligibility is established. This date serves as the certification date for services to be initiated.

(A) When the length of time from the initial assessment to

the date of service eligibility determination exceeds ~~90-calendar~~ninety (90)-calendar days, a new UCAT Part III and assessment visit is required.

(B) The DHS area nurse assigns a medical certification period of not more than ~~36 months.~~thirty-six (36) months for persons eighteen (18) years of age and older or not more than twelve (12) months for persons younger than eighteen (18) years of age. The service plan period under the Service Authorization Model (SAM) is for a period of ~~12~~twelve (12) months and is provided by the DHS nurse.

(7) The DHS area nurse notifies the DHS county worker via ~~ELDERS~~Electronic Data Entry and Retrieval System (ELDERS) of the personal care certification. The authorization line is open via automation from ELDERS.

(8) Upon establishment of personal care certification, the DHS nurse contacts the member's preferred provider agency, or when necessary, the secondary provider agency or the provider agency selected by the round robin system. Within ~~one-business~~one (1)-business day of provider agency acceptance, the DHS nurse forwards the referral information to the provider agency for SAM plan development. Refer to OAC 317:35-15-8(a).

(9) Following the SAM packet development by the provider agency, and within ~~three-business~~three (3)-business days of receipt of the packet from the provider agency, the DHS nurse reviews the documentation to ensure agreement with the plan. Once agreement is established, the packet is authorized by the designee or submitted to the area nurse for review.

(10) Within ~~10-business~~ten (10)-business days of receipt of the SAM case from the DHS nurse, the DHS area nurse authorizes or denies the SAM units. If the SAM case fails to meet standards for authorization, the case is returned to the DHS nurse for further justification.

(11) Within ~~one-business~~one (1)-business day of knowledge of the authorization, the DHS nurse forwards the service plan authorization to the provider agency.

317:35-15-10. Redetermination of medical eligibility for personal care services

(a) **Medical eligibility redetermination.** The Oklahoma Department of Human Services (DHS) area nurse must complete a redetermination of medical eligibility before the end of the long-term care medical certification period.

(b) **Recertification.** The DHS nurse re-assesses the personal care services member, eighteen (18) years of age and older, for medical re-certification based on the member's needs and level of caregiver support required, using the Uniform Comprehensive Assessment Tool (UCAT) Part III at least every ~~36~~thirty-six (36) months. Those

members, who are younger than eighteen (18) years of age, are re-evaluated by the DHS nurse using the UCAT Part III on a twelve (12) month basis or sooner when needed. During this re-certification assessment, the DHS nurse informs the member of the state's other SoonerCare (Medicaid) long-term care options. The DHS nurse submits the re-assessment to the DHS area nurse for recertification. Documentation is sent to the DHS area nurse no later than the ~~10th-calendar~~tenth (10th)-calendar day of the month in which the certification expires. When the DHS area nurse determines medical eligibility for personal care services, a recertification review date is entered on the system.

(c) **Change in amount of units or tasks.** When the personal care provider agency determines a need for a change in the amount of units or tasks within the personal care service, a new Service Authorization Model (SAM) packet is completed and submitted to DHS within five~~-calendar~~ (5) business days of identifying the assessed need. The change is approved or denied by the DHS area nurse or designee, prior to implementation.

(d) **Voluntary closure of ~~Personal Care~~personal care services.** When a member decides personal care services are no longer needed to meet his or her needs, a medical decision is not needed. The member and the DHS nurse or DHS county Social Services Specialist completes and signs DHS Form 02AG038E, State Plan Personal Care/ADvantage Program Voluntary Withdrawal Request. The DHS nurse submits closure notification to the provider agency.

(e) **Resuming ~~Personal Care~~personal care services.** When a member approved for ~~Personal Care~~personal care services is without ~~Personal Care~~personal care services for less than ~~90 calendar-days~~ ninety (90)-calendar-days but has current medical and SoonerCare (Medicaid) financial eligibility approval, ~~Personal Care~~personal care services may be resumed using the member's previously approved SAM packet. The personal care provider agency nurse contacts the member to determine when changes in health or service needs occurred. When changes are identified, the provider agency nurse makes a home visit and submits a ~~Personal Care~~personal care services skilled nursing re-assessment of need within ~~10-business~~ten (10)-business days of the resumed plan start date, using the State Plan Personal Care Progress Notes, DHS Form 02AG044E. When the member's needs dictate, the ~~Personal Care~~personal care provider agency may submit a request for a change in authorized ~~Personal Care~~personal care services units with a SAM packet to DHS. When no changes occur, the agency nurse documents the contact on State Plan Personal Provider Communication Form 02AG032E and forwards it to the DHS nurse within ~~10-business~~ten (10)-business days of the resumed plan start date.

(f) **Financial ineligibility.** When the DHS determines a ~~Personal Care~~personal care services member does not meet SoonerCare

financial eligibility criteria, the DHS office notifies the DHS area nurse to initiate the closure process due to financial ineligibility. Individuals determined financially ineligible for ~~Personal Care~~personal care services are notified by DHS in writing of the determination and of their right to appeal the decision. The DHS nurse submits closure notification to the provider agency.

(g) **Closure due to medical ineligibility.** Individuals determined medically ineligible for ~~Personal Care~~personal care services are notified by DHS in writing of the determination and of their right to appeal the decision. When medical eligibility redetermination is not made prior to current medical eligibility expiration, the existing medical eligibility certification is automatically extended until level of care redetermination is established. For members:

(1) who are not hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for a maximum sixty (60)-calendar days from the date of the previous medical eligibility expiration date;

(2) who are hospitalized or in an extended medical care facility, the existing medical eligibility certification is extended for thirty (30)-calendar days from the date of discharge from the facility or for sixty (60)-calendar days from the date of previous medical eligibility expiration date, whichever is longer;

(3) whose medical eligibility redetermination is not made by applicable extended deadline, the member is determined to be no longer medically eligible; or

(4) who no longer meet medical eligibility or cannot be located to complete the redetermination assessment, the area nurse or nurse designee, updates the system's medical eligibility end date and notifies the DHS State Plan Care Unit (SPCU) nurse of effective end date. The DHS SPCU nurse submits closure notification to the provider agency.

(h) **Termination of State Plan ~~Personal Care Services.~~personal care services.**

(1) Personal ~~Care~~care services may be discontinued when:

(A) the member poses a threat to self or others as supported by professional documentation;

(B) other members of the household or persons who routinely visit the household who, as supported by professional documentation or other credible documentation, pose a threat to the member or other household visitors;

(C) the member or the other household members use~~:~~ threatening, intimidating, degrading, or sexually inappropriate language and/or innuendo or behavior towards service providers, either in the home or through other contact or communications; and efforts to correct such

behavior were unsuccessful as supported by professional documentation or other credible documentation.

~~(i) angry, insulting, threatening, intimidating, degrading, or sexually inappropriate language; or~~
~~(ii) innuendos or behavior towards service provider, whether in the home or through other contact or communications; or~~
~~(iii) as supported by professional documentation or other credible documentation.~~

(D) the member or family member fails to cooperate with Personal Care service delivery or to comply with Oklahoma Health Care Authority (OHCA) or DHS rules as supported by professional documentation;
(E) the member's health or safety is at risk as supported by professional documentation;
(F) additional services, either "formal" such as, paid by Sooner Care (Medicaid) or some other funding source or "informal" such as, unpaid are provided in the home eliminating the need for SoonerCare ~~Personal Care~~personal care services;
(G) the individual's living environment poses a physical threat to self or others as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible; or
(H) the member refuses to select and/or accept the services of a provider agency or ~~PCA~~personal care assistant (PCA) for ~~90-consecutive~~ninety (90)-consecutive days as supported by professional documentation.

(2) For persons receiving personal care services, the personal care provider agency submits documentation with the recommendation to discontinue services to DHS. The DHS nurse reviews the documentation and submits it to the DHS area nurse for determination. The DHS nurse notifies the personal care provider agency or PCA~~,~~ and the local DHS county worker of the decision to terminate services. The member is sent an official closure notice informing him or her of appropriate member rights to appeal the decision to discontinue services.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-14. Case management services

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

(1) Within ~~one-business~~one (1)-business day of receipt of an

ADvantage referral from the ADvantage Administration (AA), the case management supervisor assigns a case manager to the member. The case manager makes a home visit to review the ADvantage program; its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, and the Oklahoma Department of Human Services (DHS). The case manager will review~~;~~ and/or update~~ and complete~~ the Uniform Comprehensive Assessment Tool (UCAT)~~;~~ Part III and discuss service needs and ADvantage service providers. The ~~Case Manager~~case manager notifies the member's primary physician, identified in the UCAT ~~identified primary physician~~Part I, in writing that the member was determined eligible to receive ADvantage services. The notification is a preprint form that contains the member'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~~.~~ Part III.

(2) Within ~~14-calendar~~fourteen (14)-calendar days of the receipt of an ADvantage referral, the case manager completes and submits~~ to the AA~~ a person-centered service plan~~ and service plan~~ for the member, signed by the member and the case ~~management supervisor.~~manager, to the case manager supervisor for approval and submission to the AA. The case manager completes and submits~~ to the AA~~ the annual reassessment person-centered service plan documents no sooner than ~~60-calendar~~sixty (60)-calendar days before the existing service plan ~~end date~~end-date but sufficiently in advance of the ~~end date~~end-date to be received by the AA at least ~~30-calendar~~thirty (30) days before the ~~end date~~end-date of the existing person-centered service plan. The case manager submits revisions for denied services to be resubmitted~~ to the AA~~ for approval within ~~5-business~~five (5)-business days~~.~~ to the AA. Within ~~14-calendar~~fourteen (14)-calendar days of receipt of a Service Plan Review~~ Request~~ (SPR) for short-term authorizations from the AA, the case manager ~~provides~~submits corrected person-centered service plan documentation. Within ~~five-business~~five (5)-business days of assessed need, the case manager completes and submits a service plan addendum to the AA to amend current services on the person-centered service plan. The person-centered~~ and~~ service plan is based on the member'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 member. The case manager uses an interdisciplinary team (IDT) planning approach for person-centered service plan development. Except for extraordinary circumstances, the IDT meetings are held in the member's home. ~~Variances from this policy must be presented to and approved by~~

~~the AA in advance of the meeting.~~ When ~~in-home~~home care is the primary service, the IDT includes, at a minimum, the member, a nurse from the ADvantage ~~in-home~~home care ~~provider~~or assisted living provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

(3) The case manager identifies long-term goals, strengths and challenges ~~to~~for meeting goals, and service goals including plan objectives, actions steps and expected outcomes. The ADvantage case manager documents on the person-centered service plan~~,~~ the presence of two (2) or more ADvantage members residing in the same household and/or when the member and personal care provider reside together. The case manager documents on the Electronic Visit Verification (EVV) system in the member record any instance in which a member's health or safety would be at risk when even one (1) personal care visit is missed. 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 member signs and indicates review/agreement with the person-centered service plan by indicating acceptance or non-acceptance of the plans. The member, the member's legal guardian~~,~~ or legally authorized representative signs the person-centered service plan in the presence of the case manager. The signatures of two (2) witnesses are required when the member signs with a mark. When the member refuses to cooperate in development of the person-centered service ~~planor~~plan or when the member refuses to sign the person-centered service plan, the case management agency refers the case to the AA for resolution. ~~In addition based~~Based on the UCAT Part III and/or case progress notes that document chronic uncooperative or disruptive behaviors, the DHS nurse or AA may identify members that require AA intervention through referral to the AA's Escalated Issues unit.

(A) For members that are uncooperative or disruptive, the case manager ~~develops~~supports the member to develop an individualized person-centered service~~ individualized~~ plan to overcome challenges to receiving services. ~~focusing~~This plan focuses on behaviors, both favorable and those that jeopardize the member's well-being and includes a design approach of incremental plans and~~ an~~ addenda that allows the member to achieve stepwise successes in behavior modification.

(B) The AA may implement a person-centered service plan without the member's signature when the presence of a document that requires their signature may itself trigger a conflict. In these circumstances, mental health/behavioral issues may prevent the member from controlling his or her

behavior to act in his or her own interest. ~~The person~~When the member, by virtue of level of care and the IDT assessment, needs ADvantage services to ensure his or her health and safety, the AA may authorize the person-centered service plan when the case manager demonstrates effort to work with and obtain the member's agreement. Should negotiations not result in agreement with the person-centered service plan, the member may withdraw his or her request for services or request a fair hearing.

(4) Consumer-Directed Personal Assistance Services and Supports (CD-PASS) planning and supports coordination.

(A) ~~The ADvantage case management provider assigns the CD-PASS member a case manager that successfully completed training on CD-PASS, Independent Living Philosophy, Person-Centered Planning and the individual budgeting process and process guidelines. Case managers, who complete specialized CD-PASS training are referred to as Consumer-Directed Agent/Case Managers (CDA/CM) with respect to his or her CD-PASS service planning and support role in working with CD-PASS members. The CDA/CM educates the member about his or her rights and responsibilities as well as community resources, service choices, and options available to the member to meet CD-PASS service goals and objectives.~~CD-PASS offers ADvantage members personal choice and control over the delivery of their in-home support service, including who provides the services and how services are provided. Members or their legal representatives have singular "employer authority" in decision-making and are responsible to recruit, hire, train, supervise and when necessary, terminate the individuals who furnish their services. They also have "budget authority" to determine how expenditures of their expense accounts are managed.

(B) ~~The member may designate a family member or friend as an authorized representative to assist in the service planning process and in executing member employer responsibilities. When the member chooses to designate an authorized representative the designation and agreement identifying the willing adult to assume this role and responsibility is documented with dated signatures of the member, the designee, and the member's case manager, or AA staff.~~Members who elect the CD-PASS service option receive support from Consumer-Directed Agent/Case Manager (CDA/CM) in directing their services. The CDA/CM liaison between the member and the program assists members, identifying potential requirements and supports as they direct their services and supports. ADvantage case management providers deliver required support and assign the CD-PASS members a case

manager trained on the ADvantage CD-PASS service option, independent living philosophy, person centered service planning, the role of the member as employer of record, the individual budgeting process and service plan development guidelines. A case manager, who has completed specialized CD-PASS training, is referred to as a CDA/CM with respect to the service planning and support role when working with CD-PASS members. The CDA/CM educates the member about his or her rights and responsibilities as well as community resources, service choices and options available to the member to meet CD-PASS service goals and objectives.

~~(i) A person having guardianship or power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated authorized representative.~~

~~(ii) An individual hired to provide CD-PASS services to a member may not be designated the authorized representative for the member.~~

~~(iii) The case manager reviews the designation of authorized representative, power of attorney, and legal guardian status on an annual basis and includes this in the reassessment packet to AA.~~

(C) The ADvantage case management provider is responsible for ensuring that case managers serving members who elect to receive or are receiving the CD-PASS service option have successfully completed CD-PASS certification training in its entirety and have a valid CDA/CM certification issued by the AA.

(D) Consumer-directed, SoonerCare (Medicaid)-funded programs are regulated by federal laws and regulations setting forth various legal requirements with which states must comply. The ADvantage case management provider is responsible for ensuring that CDA/CMs in their employment provide services to CD-PASS members consistent with certification guidelines so as to be in keeping with federal, state, and Waiver requirements. Non-adherence may result in remediation for the case management provider, the case manager, or both, up to and including decertification.

(E) Members may designate a family member or friend as an authorized representative to assist in the service planning process and in executing member employer responsibilities. When the member chooses to designate an authorized representative, the designation and agreement, identifying the willing adult to assume this role and responsibility, is documented with dated signatures of the member, the designee, and the member's case manager, or AA staff.

(i) A person having guardianship or power of attorney or

other court-sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated authorized representative.

(ii) An individual hired to provide CD-PASS services to a member may not be designated the authorized representative for the member.

(iii) The case manager reviews the designation of authorized representative, power of attorney, and legal guardian status on an annual basis and includes this in the reassessment packet to AA.

~~(C)~~(F) The CDA/CM provides support to the member in the ~~Person-Centered~~person-centered CD-PASS ~~Planning~~planning process. Principles of ~~Person-Centered Planning~~person-centered planning are listed in (i) through (v) of the subparagraph.

(i) The person is the center of all planning activities.

(ii) The member and his or her representative, or support team are given the requisite information to assume a controlling role in the development, implementation, and management of the member's services.

(iii) The individual and those who know and care about him or her are the fundamental sources of information and decision-making.

(iv) The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals, and support needs.

(v) ~~Person-Centered Planning~~Person-centered planning results in personally-defined outcomes.

~~(D)~~(G) The CDA/CM encourages and supports the member, or as applicable his or her designated authorized representative, to lead, to the extent feasible, the CD-PASS service planning process for ~~Personal Services Assistance.~~personal services assistance. The CDA/CM helps the member define support needs, service goals, and service preferences including access to and use of generic community resources. Consistent with member-direction and preferences, the CDA/CM provides information and helps the member locate and access community resources. Operating within the constraints of the Individual Budget Allocation (IBA) units, the CDA/CM assists the member translate the assessment of member needs and preferences into an individually tailored, person-centered service plan.

~~(E)~~(H) To the extent the member prefers, the CDA/CM develops assistance to meet member needs using a combination of traditional ~~Personal Care~~personal care and CD-PASS PSA services. However, the CD-PASS IBA and the PSA unit

authorization is reduced proportional to agency ~~Personal Care~~personal care service utilization.

~~(F)~~(I) The member determines with the PSA to be hired, a start date for PSA services. The member coordinates with the CDA/CM to finalize the person-centered service plan. The start date must be after:

(i) authorization of services;

(ii) completion and approval of the background checks; and

(iii) completion of the member employee packets.

~~(G)~~(J) Based on outcomes of the planning process, the CDA/CM prepares an ADvantage person-centered service plan or plan amendment to authorize CD-PASS ~~Personal Service Assistance~~personal service assistance units consistent with this individual plan and notifies existing duplicative ~~Personal Care~~personal care service providers of the ~~end date~~end-date for those services.

~~(H)~~(K) When the plan requires an Advanced Personal Service Assistant (APSA) to provide assistance with health maintenance activities, the CDA/CM works with the member and, as appropriate, arranges for training by a skilled nurse for the member or member's family and the APSA to ensure that the APSA performs the specific health maintenance tasks safely and competently~~;~~, when the;

(i) ~~when the~~ member's APSA was providing Advanced Supportive Restorative Assistance to the member for the same tasks in the period immediately prior to being hired as the APSA, additional documentation of competence is not required; and

(ii) ~~when the~~ member and APSA attest that the APSA was performing the specific health maintenance tasks to the member's satisfaction on an informal basis as a friend or family member for a minimum of two (2) months in the period immediately prior to being hired as the PSA, and no evidence contra-indicates the attestation of safe and competent performance by the APSA, additional documentation is not required.

~~(I)~~(L) The CDA/CM monitors the member's well-being and the quality of supports and services and assists the member in revising the PSA services plan as needed. When the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the CDA/CM, based upon an updated assessment, amends the person-centered service plan to modify CD-PASS service units appropriate to meet the additional ~~member's~~ need and ~~forwards~~submits the plan amendment to the AA for

authorization and update of the member's IBA.

~~(J)~~(M) In the event of a disagreement between the member and CD-PASS provider the following process is followed:

(i) either party may contact via a toll free number the Member/Provider Relations Resource Center to obtain assistance with issue resolution;

(ii) when the issue cannot be resolved with assistance from the Member/Provider Relations Resource Center or from CD-PASS Program Management, the CD-PASS Program Management submits the dispute to the ADvantage Escalated Issues Unit for resolution. The Escalated Issues Unit works with the member and provider to reach a mutually-agreed upon resolution;

(iii) when the dispute cannot be resolved by the ADvantage Escalated Issues Unit it is heard by the Ethics of Care Committee. The Ethics of Care Committee makes a final determination with regard to settlement of the dispute; or

(iv) at any step of this dispute resolution process the member may request a fair hearing to appeal the dispute resolution decision.

~~(K)~~(N) The CDA/CM and the member prepare an emergency backup response capability for CD-PASS PSA/APSA services in the event a PSA/APSA services provider essential to the individual's health and welfare fails to deliver services. As part of the backup planning process, the CDA/CM and member define what failure of service or neglect of service tasks constitutes a risk to health and welfare to trigger implementation of the emergency backup (i) or (ii) may be used. Identification of:

(i) ~~Identification of~~ a qualified substitute provider of PSA/APSA services and preparation for their quick response to provide backup emergency services, including execution of all qualifying background checks, training, and employment processes; and/or

(ii) ~~Identification of~~ one (1) or more qualified substitute ADvantage agency service providers, adult day health, personal care, or nursing facility (NF) respite provider, and preparation for quick response to provide backup emergency services.

~~(L)~~(O) To obtain authorizations for providers other than PSA and APSA identified as emergency backups, requests the AA authorize and facilitate member access to adult day health, agency personal care, or ~~Nursing Facility~~NF respite services.

(5) The case manager submits the person-centered service plan to the case management supervisor for review. The case

management supervisor ~~documents~~conducts the review/approval of the plans within ~~two-business~~two (2)-business 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 person-centered service plan to the case management supervisor within ~~two-business~~two (2)-business days. The case management supervisor returns the approved person-centered service plan to the case manager. Within ~~one-business~~one (1)-business day of receiving supervisory approval, the case manager ~~forwards,~~submits, ~~by United States mail, a legible copy of~~ the person-centered service plan to the AA. ~~Case managers are responsible for retaining all original documents for the member's file at the agency.~~ Only priority service needs and supporting documentation may be ~~faxed~~submitted to the AA ~~with the word, "PRIORITY" clearly indicated and the~~as a "Priority" case with justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the NF. Corrections to service conditions set by the AA are not considered a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a NF.

(6) Within ~~one-business~~one (1)-business day of notification of care plan and person-centered service plan authorization, the case manager communicates with the service plan providers and member to facilitate service plan implementation. Within ~~five-business~~five (5)-business days of notification of an initial person-centered service plan or a new reassessment service plan authorization, the case manager visits the member, gives the member a copy of the person-centered service plan ~~or computer-generated copy of the person-centered service plan,~~ and evaluates the service plan implementation progress. The case manager evaluates service plan implementation on the following minimum schedule:

(A) within ~~30-calendar~~thirty (30)-calendar days of the authorized effective date of the person-centered service plan or service plan addendum amendment; and

(B) monthly after the initial ~~30-calendar~~thirty (30)-calendar follow-up evaluation date.

(b) **Authorization of service plans and amendments to service plans**. The AA authorizes the individual person-centered service plan and all service plan amendments for each ADvantage member. When the AA verifies member ADvantage eligibility, service plan cost ~~effectivenessfor~~effectiveness for service providers that are ADvantage authorized and SoonerCare contracted, and that the

delivery of ADvantage services are consistent with the member's level of care need, the service plan is authorized.

(1) Except as provided by the process per ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-761(6), 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 member, such as the spouse or parent of a minor child.

(2) ~~The~~ DHS AS may, per OAC 317:35-15-13, authorize personal care service provision by an Individual PCA, an individual contracted directly with OHCA. Legally responsible family members are not eligible to serve as Individual PCAs.

(3) When ~~the~~a complete service plan authorization or amendment request ~~packet~~is received ~~from case management is complete~~ and the service plan is within cost-effectiveness guidelines, the AA authorizes or denies authorization within ~~five-business~~five (5)-business days of receipt of the request. When 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 member to access services in an alternate setting or program. When the request packet is ~~not complete,~~incomplete, the AA notifies the case manager immediately and puts a hold on authorization until the ~~required additional documents~~requirements are received from case management.

(4) The AA authorizes the service plan by entering the authorization date ~~and assigning a control number that internally identifies the DHS staff completing the authorization~~. Notice of authorization ~~and a computer-generated copy of the authorized plan or a computer-generated copy~~ of the ~~authorized~~service plan ~~are provided to case management.~~is available through the appropriate designated software or web-based solution. AA authorization determinations are provided to case management within ~~one-business~~one (1)-business day of the authorization date. A person-centered 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 within ~~5-business~~five (5)-business days.

(5) For audit purposes including Program Integrity reviews, the ~~computer-generated copy of the~~ authorized service plan is documentation of service authorization for ADvantage waiver and State Plan Personal Care services. Federal or State quality review and audit officials may obtain a copy of specific person-centered service plans with original signatures by submitting a request to the member's case manager.

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

(1) The service provider initiates the process for an increase or decrease in service to the member's person-centered service plan. The requested changes and justification are documented by the service provider and, when initiated by a direct care provider, are submitted to the member's case manager. When in agreement, the case manager ~~requests~~submits the service changes ~~on a service plan amendment submitted to the AA~~ within ~~five-business~~five (5)-business days of the assessed need. The AA authorizes or denies the person-centered service plan changes, per ~~Oklahoma Administrative Code (OAC)~~OAC 317:35-17-14.

(2) The member initiates the process for replacing ~~Personal Care~~personal care services with ~~Consumer-Directed Personal Services and Supports (CD-PASS)~~CD-PASS in geographic areas where CD-PASS services are available. The member may contact the AA or call the toll-free number to process requests for CD-PASS services.

(3) A significant change in the member's physical condition or caregiver support, one that requires additional goals, deletion of goals or goal changes, or requires a ~~four-hour~~four (4)-hour or more adjustment in services per week, requires an updated UCAT Part III reassessment by the case manager. The case manager develops an amended or new person-centered service plan, as appropriate, and submits the new amended person-centered service plan for authorization.

(4) One (1) or more of the following changes or service requests require an Interdisciplinary Team review and service plan goals amendment:

(A) the presence of two (2) or more ADvantage members residing in the same household;

(B) the member and personal care provider residing together;

(C) a request for a family member to be a paid ADvantage service provider; or~~,~~

(D) a request for an individual PCA service provider.

(5) Based on the reassessment and consultation with the AA as needed, the member may, as appropriate, be authorized for a new person-centered service plan or be eligible for a different service program. When the member is significantly improved from the previous assessment and does not require ADvantage services, the case manager obtains the member's dated signature indicating voluntary withdrawal for ADvantage program services. When unable to obtain the member's consent for voluntary closure, the case manager requests ~~(AA)~~AA assistance. The AA requests that the DHS area nurse initiate a reconsideration of level of care.

(6) Providers of Home and Community Based Services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates the only willing and qualified entity to provide case management and develop person-centered service plans in a geographic area also provides HCBS.

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the Oklahoma Medicaid Management Information Systems (OKMMIS) Billing and Procedure Manual. Questions regarding billing procedures that cannot be resolved through a study of the manual are referred to the Oklahoma Health Care Authority (OHCA).

(b) The Oklahoma Department of Human Services (DHS) Aging Services (AS) approved ADvantage service plan is the basis for the Medicaid Management Information Systems (MMIS)service prior authorization, specifying~~:~~ the:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin- and ~~end dates~~end-dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits are used to evaluate if paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims not supported by service plan authorization and/or documentation of service provision are turned over to the OHCA ~~Provider Audit~~Clinical Provider Audits Unit for follow-up investigation.

(d) All contracted providers for ADvantage Waiver services must submit billing to the State Medicaid agency, Soonercare using the appropriate designated software, or web-based solution to submit all claims transactions. When the designated system is unavailable, contracted providers submit billing directly to OHCA.

~~(d)~~(e) Service time of personal care, case management, case management for transitioning, nursing, advanced supportive/restorative assistance, in-home respite, consumer-directed personal assistance services and supports (CD-PASS), personal services assistance, and advanced personal services assistance is documented solely through the Electronic Visit Verification System (EVV)~~ also known as Interactive Voice Response Authentication (IVRA) system,~~ when provided in the home. Providers are required to use the EVV system. The EVV system provides alternate backup solutions when the automated system is unavailable. In the event of EVV system failure, the provider documents time in accordance with internal policy and procedures. This documentation suffices to account for in-home and office

services delivered. Provider agency backup procedures are only permitted when the EVV system is unavailable.

~~(e)~~(f) The provider must document the amount of time spent for each service, per Oklahoma Administrative Code (OAC) 317:30-5-763. For service codes that specify a time segment in their description, such as ~~15~~fifteen (15) minutes, each timed segment equals one (1) unit. Only time spent fulfilling the service for which the provider is authorized, per OAC 317:30-5-763 is authorized for time-based services. Providers do not bill for a unit of time when not more than one-half of a timed unit is performed~~. For example~~, such as, when a unit is defined as ~~15~~fifteen (15) minutes, providers do not bill for services performed for less than eight (8) minutes. The rounding rules utilized by the EVV and web-based billing system to calculate the billable unit-amount of ~~are,~~care, services provided for duration of:

(1) less than ~~8-minutes~~eight (8) minutes cannot be rounded up and do not constitute a billable ~~15-minute~~fifteen (15)-minute unit; and

(2) ~~8 to 15~~eight (8) to fifteen (15) minutes are rounded up and do constitute a billable ~~15-minute~~fifteen (15)-minute unit.

(g) Providers required to use EVV must do so in compliance with OAC 317:30-3-4.1, Uniform Electronic Transaction Act (UETA). Providers must ensure:

(1) an established process is in place to deactivate an employee's access to EVV or designated system records upon termination of employment of the designated employee;

(2) safeguards are put in place to ensure improper access or use of EVV or designated system is prohibited and sanctions will be applied for improper use or access by staff;

(3) that staff providing or delivering in-home personal care services must use the EVV system for checking-in and checking out when providing services;

(4) staff delivering personal-care services is trained in the use of the EVV system;

(5) a record of services delivered is maintained;

(6) that staff confirms in writing that they will use the system as they are trained or directed;

(7) that staff will access the system using their assigned personal identification number (PIN) for in-home service delivery;

(8) staff accessing EVV or other designated systems for billing, properly use the authentication features of the system to properly document work and confirm work that is submitted for billing for services that were rendered;

(9) procedures as outlined in the UETA pertaining to electronic signatures, will be applied at such time when use of the electronic signatures is approved and applicable for necessary

transaction;
(10) the EVV or other designated system is responsible for retention of all records that are associated with and generated for the purpose of claims and billing submitted for payment of services rendered;
(11) that they produce and enforce a security policy that outlines who has access to their data and what transactions employees are permitted to complete as outlined; and
(12) when using EVV or other designated system for billing and claims submissions, each new invoice or claim, must include the following information in (i) through (vi). The:
(i) type of service performed;
(ii) individual receiving the services;
(iii) date of the service;
(iv) location of service delivery;
(v) individual providing the service; and
(vi) time the service begins and ends.

SUBCHAPTER 19. NURSING FACILITY SERVICES

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

The ~~DHS~~Oklahoma Department of Human Services (DHS) area nurse or nurse designee, determines medical eligibility for ~~nursing facility (NF)~~NF services based on the ~~long term care (LTC)~~DHS nurse's Uniform Comprehensive Assessment Tool ~~(UCAT III)~~(UCAT) Part III assessment of the client's needed level of care, the outcome of the Level II Preadmission Screening and Resident Review (PASRR), when completed, and his or her professional judgment. The Oklahoma ~~Healthcare~~Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) makes some determinations when the ~~(PASRR)~~PASRR is involved. Refer to Oklahoma Administrative Code (OAC) 317:35-19-7.1(3) for ~~nursing facility~~NF 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~~DHS nurse reviews the PASRR Level I in the ~~Oklahoma Health Care Authority~~OHCA system; completes the UCAT III; and enters the date OHCA received the PASRR Level I (LTC-300R) from the NF and admission date to the NF; ~~financial~~medical eligibility effective date and notes any Level II PASRR results if available in the UCAT Part III. This information is submitted to the DHS ~~Area Nurse~~area nurse 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 Part III assessment to be completed prior to admission, the NF is responsible for notifying the DHS of the admission. Notification is mailed or faxed on DHS Form 08MA083E, Notification ~~regarding~~Regarding Patient In A Nursing Facility, Intermediate Care Facility for the ~~Mentally Retarded~~Intellectually Disabled or Hospice, and Management Recipient Funds to the local DHS county office. Upon receipt, the DHS county office processes~~ Forms 08MA084E and 08MA084EForms~~ Forms 08MA083E and 08MA084E and completes and forwards the Form 08MA038E, Notice Regarding Financial Eligibility to the NF. Identified sections of the UCAT Part III 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, confirms the date of medical eligibility and records it in the system. The facility is responsible for performing the PASRR Level I screen and consulting with OHCA staff to determine when a need exists for a Level II screen. The ~~LTC~~DHS nurse ~~conducts~~completes the assessment~~ visit~~ within ~~15-business~~fifteen (15)-business days of PASRR clearance when the individual's needs are included in an active DHS coded case. When the individual's needs are not included in an active case, the assessment is ~~conducted~~completed within ~~20-business~~twenty (20)-business days of PASRR clearance.
(5) The area nurse or nurse designee, evaluates the PASRR Level I screen and the UCAT Part III in consultation with the DHS nurse when the completed LTC-300R and/or facility documentation shows a need exists for a possible Level II screen. The area nurse or nurse designee consults with OHCA staff as necessary.
(6) The area nurse or nurse designee, evaluates the UCAT Parts I and III, to determine if 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 on the client's needs. The area nurse or nurse designee, enters the medical eligibility decision and, when required, the medical certification review date into Aging Services Division Electronic Data Entry and Retrieval System (ELDERS) within ~~10-business~~ten (10)-business days. A medical eligibility redetermination is not required when a client is discharged from the NF for a period not to exceed ~~90-calendar~~ninety (90)-calendar days and the original certification is current.
(7) When the ~~LTC~~DHS 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~~DHS nurse can submit additional information to the area nurse or nurse

designee. When necessary, a visit by the ~~LTC~~DHS nurse to obtain additional information is initiated at the recommendation of the area nurse or nurse designee.

(8) Categorical relationship must be established for determination of eligibility for NF services. When categorical relationship to disability has not been established, the worker submits the same information, per 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 applicant using the Social Security Administration (SSA) definition. A follow-up with the SSA by the DHS worker is required to ensure the SSA disability decision agrees with the LOCEU decision.