Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

May 13, 2021
1:00 – 3:30 PM
Teleconference
OKC, OK

AGENDA

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes, O.D.**

II. Action Item: Approval of Minutes of the March 11th, 2020: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Tasha Black, Senior Director of Financial Services**

VI. SoonerCare Operations Update: **Melody Anthony, Chief Operating Officer**

VII. Peripheral Nerve Stimulation Presentation: **Mike Herndon, Chief Medical Officer**

VIII. Legislative Update: **Christina Foss, Legislative Liaison**

IX. IMD Waiver Post Award Forum: **Melissa Miller, Director of Medicaid Behavioral Health Policy and Planning with ODMHSAS**

X. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Director of Federal & State Authorities**

- **A. 21-02 State Plan Personal Care Services**
- **B. 21-03 Remove Reasonable Limits to Amounts for Necessary Medical and Remedial Care not Covered Under the Oklahoma Medicaid State Plan**
- **C. 21-05A&B Medicaid Expansion and Prosthetics and Orthotics Changes**
- **D. 21-06 Insure Oklahoma (IO) Individual Plan (IP) and Timely Filing**
- **E. 21-07 Payments from Trusts for Clothing Expenses not Counted as Income**

XI. New Business: **Chairman, Jason Rhynes, O.D.**

XII. Future Meeting: **Chairman, Jason Rhynes, O.D.**
July 8, 2021
September 9, 2021
November 4, 2021

XIII. Adjourn **Chairman, Jason Rhynes, O.D.**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the March 11, 2021 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

Delegates present were: Ms. Sarah Baker, Ms. Debra Billingsly, Ms. Kristi Blackburn, Ms. Mary Brinkley, Dr. Erin Balzer, Mr. Joe Catalano, Mr. Victor Clay, Dr. Steven Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terrie Fritz, Ms. Allison Garrison, Dr. Craig Kupiec, Dr. Lori Holmquist-Day, Ms. Annette Mays, Ms. Melissa Miller, Dr. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Dwight Sublett, Ms. Mitzi McCullock, Mr. William Whited, and Dr. Whitney Yeates.

Alternates present were: Mr. Terry Bryce providing a quorum.

***Delegates absent without an alternate were*:** Mr. Brett Coble, Mr. Steve Goforth, Mr. James Patterson, Dr. Raymond Smith, and Mr. Jeff Tallent.

II. Approval of the November 12th, 2020 Minutes

Medical Advisory Committee
The motion to approve the minutes was by Dr. Steven Crawford and seconded by Ms. Terrie Fritz and passed unanimously.

III. Public Comments (2 minute limit):

Dr. Grant Ward spoke regarding an issue about a law that was passed that requiring certification, specifically, ABA certification to perform and bill behavioral analysis in Oklahoma. The issue is that law would appear to restrict what is already allowed under the licensure for psychologist. Dr. Ward is a psychologist himself, but also a business owner. Many of his patients are on the spectrum that behavioral analysis is used, and that is the common training for colleges who prepare specialists to work with this population. So, requiring their certification for them to do something, they are already licensed to do, first doesn't make sense, and as a business owner, it will complicate my ability to bring in a college from out of state, which is where I find most of my experts for Autism.

Mr. Bobby Martin spoke regarding the same issue as Dr. Ward. As a psychologist who has worked with BCBH for sometimes, along with the process, therapy used, and it's about, having the idea, that the psychologist would be able to bill for a service that they had developed and created, long before the BCBA certification was started in the 1990's. Its much like someone who specializes in some medical procedure, saying a physician or medical doctor can no longer bill for that because now they can't do it. We have trained the BCBA's on what to do, and I support them, but their training comes from the development, and practices through phycology. I think its more of a misunderstanding,

that when that rule was created for billing purposes, but 100% backing up Dr. Ward was saying, we need to make sure phycologists bill for the procedure that they are well trained to do.

Ms. Danna Fowble spoke on behalf of Dr. Susan Howard. She wanted the MAC committee to know that, as a phycologist, be reminded, that we follow our ethic principles on practicing within our scope pf treatment, and we, as professionals, are capable of knowing what those parameters are just like a medical practitioner knows, if he or she, should perform a certain service. It is not up to the BCBA Board to determine what guidelines phycologists should have in our practice. For example, she has extensive training in ABA and was supervised by a phycologist, who was an Applied Behavior Analyst, which occurred 30 years ago, she sought this person out on her own as she didn't have programs available like the BCBA that is developed today. As a result of her phycologist training supervision and 30 years of working with children on the spectrum, she feels fully qualified to implement services. She does not have a BCBA, or BCA course work, but as a psychologist, she doesn't believe that is necessary based on the training, experience, and knowledge and the rules that govern her practice. A state board oversees our ethical guidelines and upholds such standards when a phycologist doesn't follow those guidelines.

Ms. JDene Roger stated that she was curious as to why there was even an issue, or question on whether or not a doctoral level phycologist would be able to conduct ABA therapy. Throughout our years of education, and most often during our subsequent training, supervision, and experience, we routinely utilize the tenets of, behavioralist, behavioral theory, and therapy behavioral modification, etc. APA defines phycologist as the scientific study of mind and behavior. ABA is defined as science and study of behavior. To try and see if I am missing something, I contacted the Chicago School of Phycology and the Oklahoma Licensed Behavioral Analysis board, and asked what they believe any further studies, supervision, testing etc. might offer me in that I am not already trained and utilized in my work as a phycologist, other than perhaps a few more letters behind my name, the resounding answer, from all that I spoke with, was probably nothing. I would agree to say that I need more education, or supervision, by one that has less likely more education, or experience, than I, to do what I have been affectively doing for almost 30 years.

Dr. Stephen Gillaspy spoke regarding the same issue. It is important to understand the history of behavioralism, which was later solidified in the science of applied behavior analysis. The science and the treatments were developed in clinical phycology programs. Its also important to acknowledge that applied behavioral analysts is a science, it is not a treatment nodality. ABA is a set of scientifically proven principles of modified behavior. New evidence based off phycological treatment are developed to the fundamental principal of applied behavior analysis. As the field and science of behavior treatments progress, the BCBA was developed by a subset of providers. The overwhelming majority of the BCBAs, are trained in the bachelors, and master's level. These programs did not have a pathway to become a provider, and a certification or different license was needed to create a pathway for them to practice. So, for a phycologist, being licensed as a health service provider is the

highest level of recognition, much higher than a certification. The ABA certification was designed primarily for bachelors, and masters level providers, and it would be redundant to require a licensed phycologist to obtain the additional certification.

IV. MAC Member Comments/Discussion:

Ms. Terrie Frtitz asked for an update on the re-organization of the MAC. Ms. Melody Anthony responded stating that this was legislation that was supposed to move forward last session, but because of COVID19 things were pushed back. The explanation behind moving forward with this change, is to re-set the MAC and make sure we are staying within the regulations of what the MAC does, how its structured, and the members of that body. It also gets us back to being able to set years of participation, something that we put in writing many years ago but were never able to actually figure out the best way to monitor that process. Members can only serve for three years and the Chair and Vice-Chair can only be in that position for three consecutive years and then we move forward with other members.

V. Financial Report:

Tasha Black, Senior Director of Financial Services

Ms. Black presented the financial report ending in December 2020. OHCA is 1.1% under budget in revenues and 2.3% under budget in expenditures with the result that our budget variance is a positive $25,922,175. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 20.2 million state dollars, and administration is a positive 0.5 million state dollars. Drug Rebate is 4.2 million state dollars under budget. Taxes and Fees, which also included tobacco tax is 0.7 million state dollars over budget. For more detailed information, see item 5 in the MAC agenda. For more detailed information, see item 5 in the MAC agenda.

VI. SoonerCare Operations Update:

Melinda Thomason, Senior Director for Stakeholder Engagement

Ms. Thomason presented the SoonerCare Operations update to the committee. Information is based on data for January 2021. Patient Centered Medical Home enrollment is at 621,019 which is up by 517. Sooner Care Traditional has a current enrollment of 280,222 which is 4,065 more than the previous month. SoonerPlan is up by 3,557, giving a total number of 45,171. Insure Oklahoma has a total enrollment of 36,065, of which 15,675 are in the Employee Sponsored Plan, and 20,390 are in the individual plan. In total, SoonerCare enrollment is at 982,465. Total in-state providers is down 1,967, giving a total of 45,793. For more detailed information, please see item 6 in the MAC agenda.

VII. Post-Award Forum:

Sandra Puebla, Director of Federal & State Authorities

Ms. Sandra Puebla gave an update on the the SoonerCare Choice Post-Award Forum, discussing the 2019 waiver amendments, notable challenges & achievements, enrollment & budget neutrality, and the 2020 waiver amendments. For more detailed information, please see items 7 in the MAC agenda.

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Director of Federal & State Authorities

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period**.**

APA WF # 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage — The proposed revisions will add residential SUD treatment coverage for Medicaid-eligible adults, ages twenty-one (21) to sixty-four (64), and members under the age of twenty-one (21) in residential SUD treatment facilities with seventeen (17) beds or more and/or residential SUD treatment facilities with sixteen (16) beds or less. Further revisions will outline provider requirements, medical necessity, service plan, and reimbursement policies. Other revisions will involve limited rewriting aimed at clarifying outdated policy sections and removing the institution for mental disease (IMD) exclusion for members, ages twenty-one (21) to sixty-four (64). Lastly, the proposed changes are authorized under 42 CFR 440.130(d) and comply with Oklahoma's 1115(a) IMD for serious mental illness (SMI) and SUD waiver request**.**
Budget Impact: The estimated budget impact was approved during promulgation of the emergency rule in December 2020.
Tribal Consultation: July 7, 2020 and September 1, 2020

The rule change motion to approve was by Dr. Steven Crawford and seconded by Ms. Toni Pratt-Reid and passes unanimously.

APA WF # 20-19 Appeals and Incorrect References Language Cleanup — The proposed revisions will replace incorrect rule section references with the appropriate references. Additionally, revisions will remove appeals language for programs that no longer exist and involve minor cleanup to fix grammatical and formatting errors.
Budget Impact: Budget neutral.
Tribal Consultation: November 3, 2020

The rule change motion to approve was by Ms. Terrie Fritz and seconded by Dr. Steven Crawford and passes unanimously.

APA WF # 20-22 Programs of All Inclusive-Care for the Elderly (PACE) — The proposed revisions will update policy regarding enrollment denials for PACE to reflect current business practices. Additional policy changes will add language to clarify and establish OHCA's role in reviewing justifications for expedited appeals from PACE organizations. These proposed rule changes will align policy with Section 460.122 of Title 42 of the Code of the Federal Regulations.
Budget: Budget Neutral
Tribal Consultation: November 3, 2020
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Dwight Sublett and passes unanimously.

APA WF # 20-23 Developmental Disabilities Services (DDS) — The proposed revisions will change the timeframe from ninety (90) days to one (1) calendar year for which a required physical health examination and medical evaluation can be completed when an individual is applying for the DDS Home and Community-Based Services (HCBS) waiver. These revisions improve the process of certifying cases for HCBS waivers by making it more efficient. DDS may also require a current medical evaluation when a significant change of condition, disability, or physical health status is noted. Additionally, revisions will add language defining remote services that can be provided in the member's home, family home, or employment site. Remote services are created to promote the independence of a member who receives DDS services through remote services. Revisions will also address the new agency companion household criteria and new agency companion service requirements, and modify the procedures for the DDS home profile process. Agency companion providers may not simultaneously serve more than three (3) members through any combination of companion or respite services. Further, revisions will establish new criteria on how the member is to obtain assistive technology (AT) devices and clarify instructions to staff who are providing stabilization services authorized through remote supports. The requirement to add AT devices must be prescribed by a physician with a SoonerCare contract. Additionally, the proposed revisions increase the designated amount that an area resource development staff can approve or deny for AT from $2500 up to $5000. Finally, revisions will also increase the amount the state office AT programs manager can approve for AT from $2500 to $5000 or more.
Budget: Budget Neutral
Tribal Consultation: November 3, 2020
The rule change motion to approve was by Ms. Kristi Blackburn and seconded by Ms. Wanda Felty and passes unanimously.

APA WF # 20-24 A&B ADvantage Waiver — The proposed revisions will align waiver policy with the Oklahoma Health Care Authority's overarching Electronic Visit Verification rules. Additional revisions will involve eliminating or updating outdated policy and correcting grammatical errors**.**
Budget: Budget Neutral
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Ms. Kristi Blackburn and seconded by Ms. Annette Mays and passes unanimously.

APA WF # 20-25 Peer Recovery Support Specialist (PRSS) Services in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us) — The proposed revisions will add coverage and reimbursement of PRSS services. The proposed revisions will also support other policy changes related to coverage and reimbursement of residential substance use disorder (SUD) treatment services. Further revisions will reorganize policy for clarity and correct grammatical errors.
Budget Impact: The estimated budget impact for PRSS service coverage in I/T/Us is $0 total for FY2021 and $51,093 total for FY2022. Services provided to the Native American population are 100 percent federally funded; therefore, no impact on state revenue is expected. The estimated budget impact for residential SUD treatment coverage in residential facilities was approved during promulgation of the emergency rule in December 2020.
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Joe Catalano and passes unanimously.

APA WF # 20-26 Applied Behavior Analysis (ABA) Services Revisions — The proposed revisions will clarify individualized treatment plan requirements, common ABA-based techniques, medical necessity criteria, and required documentation for ABA treatment extension requests. Additionally, the proposed revisions will allow licensed psychologists to render ABA services without additional ABA-related certification requirements. Finally, revisions will involve limited rewriting aimed at clarifying policy language.
Budget Impact: Budget neutral
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Lori Holmquist-Day and seconded by Ms. Kristi Blackburn and passes unanimously with one abstention.

APA WF # 20-27 Specialty Psychiatric Residential Treatment Facility (PRTF) Staffing and Admission Revisions — The proposed revisions will update the specialty PRTF staffing ratio from one (1) staff: three (3) members to one (1) staff: four (4) members. Revisions will also clarify inpatient psychiatric admission criteria for members under twenty-one (21) accessing specialty facilities. The proposed revisions will help support access to specialty providers for children with specialized treatment needs who are most in need of in-state specialty services.
Budget Impact: Budget neutral

Tribal Consultation: November 3, 2020 and January 5, 2021
The rule change motion to approve was by Ms. Terrie Fritz and seconded by Ms. Melissa Miller and passes unanimously.

APA WF # 20-29 Provider Refund to Member when Copayment is Over-Collected — The proposed revisions will put in policy the provider's requirement to refund any amount the provider collected from the member for copayment in error and/or collected after the family had reached its aggregate cost sharing maximum.
Budget Impact: Budget neutral
Tribal Consultation: November 3, 2020
The rule change motion to approve was by Dr. Joe Catalano and seconded by Dr. Dwight Sublett and passes unanimously.

APA WF # 20-31 State Treasurer's Achieving a Better Life Experience (STABLE) Accounts — The proposed revisions will further define rules regarding STABLE accounts by specifying that if a contribution is made to a SoonerCare member's STABLE account by another individual, and the individual making the contribution later applies for SoonerCare long-term care services, that contribution will be evaluated in accordance with OHCA long-term care eligibility rules. STABLE accounts are tax-favored savings accounts for individuals with disabilities.
Budget Impact: Budget neutral
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Steven Crawford and seconded by Ms. Wanda Felty and passes unanimously.

APA WF # 20-33 Bariatric Surgery Revisions — The proposed revisions will update bariatric surgery requirements and guidelines to reflect current business practice. Additional revisions will involve fixing grammatical and/or formatting errors, as well as, revoking obsolete sections.
Budget Impact: Budget neutral.
Tribal Consultation: September 1, 2020
The rule change motion to approve was by Dr. Steven Crawford and seconded by Ms. Kristi Blackburn and passes unanimously.

APA WF # 20-34 Dental Revisions — The proposed revisions will add "scaling in the presence of a generalized moderate or severe gingival inflammation" as a new procedure to dental policy. Additional revisions will specify that a caries risk assessment form must be documented when submitting a prior authorization for crowns. Further revisions will explain that written consent from a parent or court appointed legal guardian must be provided for any services that are rendered to a minor child. Finally, revisions will clarify billing language for administering nitrous oxide and involve cleanup of formatting and grammatical errors.

Budget Impact: The estimated budget impact, for SFY2022 would be a savings in the total amount of $8,877; with $2,851 in state share. The estimated budget impact for SFY2023 would be a savings in the total amount of $10,652, with $3,384 in state share.
Tribal Consultation: November 3, 2020
The rule change motion to approve was by Dr. Steven Crawford and seconded by Ms. Kristi Blackburn passes unanimously.

APA WF # 20-36A Lodging, Meals, and SoonerRide — The proposed revisions will update the lodging and meals policy by changing the allowed mileage radius from one hundred miles or more to fifty miles or more. This change improves access to the lodging and meals benefit and to medically necessary care. Additional changes will reformat and reorganize the existing policy to provide clarity on how the approval process works for the lodging and meals benefit.
Furthermore, the proposed revisions will update and reformat the SoonerRide Non-Emergency Transportation (NEMT) policy to provide providers and members clarity on the service. The proposed revisions will outline the specific services that SoonerRide NEMT offers and how members and long-term care facilities can request transportation assistance through SoonerRide NEMT. The proposed revisions to lodging and meals, as well as SoonerRide, will align policy with current business practices.
Budget Impact: The estimated budget impact, for SFY2022, will be an increase in the total amount of $130,033; with $41,311 state share.
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Joe Catalano and passes unanimously.

APA WF # 20-36B Lodging, Meals, and SoonerRide — The proposed revisions will remove duplicate policy regarding lodging, meals, and SoonerRide non-emergency transportation. The policies regarding these services are already outlined in the Oklahoma Health Care Authority's Chapter 30.
Budget Impact: Budget neutral.
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Dwight Sublett and seconded by Dr. Joe Catalano and passes unanimously.

APA WF # 20-37 Obstetrical (OB) Ultrasound — The proposed revisions will update the OB ultrasound policy to allow for both an abdominal and vaginal ultrasound to be performed in the first trimester when clinically appropriate and medically necessary. Currently, policy only allows for either an abdominal or vaginal ultrasound.
Budget: Budget Neutral
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Joe Catalano and seconded by Dr. Steven Crawford and passes unanimously.

APA WF # 20-38 Clinical Trials — The proposed revisions will add guidelines for coverage of clinical trials including medical necessity criteria for coverage of routine care services during a clinical trial and clarifying that other experimental and investigational treatments are not covered.
Budget Impact: Budget Neutral
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Dwight Sublett and passes unanimously.

APA WF # 20-39 Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Policy Revisions — The proposed revisions will align RHC/FQHC policy language with the Oklahoma Medicaid State Plan, federal regulations and OHCA's current business practices. Other revisions will involve limited rewriting aimed at clarifying policy language, including basic laboratory services that may be reimbursed at an RHC; mid-level professional staff requirements in RHCs; and claims' requirements to indicate the setting in which a service was provided.
Budget Impact: Budget neutral
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Ms. Kristi Blackburn and seconded by Ms. Allison Garrison and passes unanimously.

APA WF # 20-40 Medicaid-Funded Abortion Certification Requirements — The proposed revisions will align with Title 63 Oklahoma Statutes § 1-741.1 and require the Certification for Medicaid Funded Abortion form to be completed by the physician and the patient.
Budget Impact: Budget neutral
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Steven Crawford and seconded by Ms. Wanda Felty and passes unanimously.

APA WF # 20-41 Sunsetting of Health Homes — The proposed revisions will remove language and references to health homes. The health homes benefit will be phased out in September 2021; thereby, rendering the associated rule language and references obsolete. However, other care coordination models will still be in place to serve this population.
Budget Impact: The estimated budget impact will be a savings in the amount of $2,642,454 total, with $844,528 state share for SFY22 (9 months) and $2,300,475 total, with $729,021 state share for SFY23. The state share savings will be attributed to the Oklahoma Department of Mental

Health and Substance Abuse Services from the transition of services to alternative service delivery models.
Tribal Consultation: January 5, 2021
The rule change motion to approve was by Dr. Steven Crawford and seconded by Dr. Dwight Sublett and passes unanimously.

APA WF # 21-04 Diabetes Self-Management Education and Support (DSMES) Services — The proposed rule changes will clarify DSMES provider requirements for registered dieticians, registered nurses, and pharmacists. Revisions will also add other health care providers with certifications as Certified Diabetes Care and Education Specialist (CDCES) or as Board-Certified Advanced Diabetes Management (BC-ADM) as eligible DSMES providers. Other revisions will involve limited rewriting aimed at updating DSMES-related terminology.
Budget Impact: Budget neutral
Tribal Consultation: November 3, 2020
The rule change motion to approve was by Dr. Steven Crawford and seconded by Ms. Wanda Felty and passes unanimously.

IX. MAC Meeting Dates for Calendar 2021:
Chairman, Jason Rhynes, O.D.

May 13, 2021
July 8, 2021
September 9, 2021
November 4, 2021

X. **New Business:**
Chairman, Jason Rhynes, O.D.

No new business was identified.

XI. Adjourn:
Chairman, Jason Rhynes, O.D.
Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Steven Crawford and seconded by Ms. Annette Mays there was no dissent and the meeting adjourned at 4:11pm.

OKLAHOMA
Health Care Authority

FINANCIAL REPORT

For the Seven Month Period Ending January 31, 2021
Submitted to the CEO & Board

- Revenues for OHCA through January, accounting for receivables, were **$2,888,437,324** or **2.5% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,701,521,513** or **3.9% under** budget.
- The state dollar budget variance through January is a positive **$35,627,232.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		31.5
Administration		1.2
Revenues:		
Drug Rebate		2.8
Medical Refunds		.0
Taxes and Fees		0.1
Total FY 21 Variance	**$**	**35.6**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA	1
Medicaid Program Expenditures by Source of Funds	2
Other State Agencies Medicaid Payments	3
Fund 205: Supplemental Hospital Offset Payment Program Fund	4
Fund 230: Quality of Care Fund Summary	5
Fund 245: Health Employee and Economy Act Revolving Fund	6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund	7

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2021, For the Seven Month Period Ending January 31, 2021

REVENUES	FY21 Budget YTD	FY21 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 631,012,229	$ 631,012,229	$ -	0.0%
Federal Funds	1,882,047,107	1,796,176,069	(85,871,038)	(4.6)%
Tobacco Tax Collections	26,826,480	28,991,639	2,165,160	8.1%
Quality of Care Collections	49,813,772	47,124,284	(2,689,488)	(5.4)%
Prior Year Carryover	15,420,980	15,420,980	-	0.0%
Federal Deferral - Interest	150,524	150,524	-	0.0%
Rate Preservation Fund	4,092,470	4,092,470	-	0.0%
Drug Rebates	206,588,900	217,228,145	10,639,245	5.1%
Medical Refunds	22,189,862	22,073,533	(116,330)	(0.5)%
Supplemental Hospital Offset Payment Program	120,592,402	120,592,402	-	0.0%
GME Federal Disallowance Repayment - OU/OSU	-	-	-	0.0%
Other Revenues	4,924,129	5,575,051	650,921	13.2%
TOTAL REVENUES	**$ 2,963,658,854**	**$ 2,888,437,324**	**$ (75,221,530)**	**(2.5)%**

EXPENDITURES	FY21 Budget YTD	FY21 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 35,054,497**	**$ 31,031,277**	**$ 4,023,220**	**11.5%**
ADMINISTRATION - CONTRACTS	**$ 87,039,733**	**$ 86,933,855**	**$ 105,878**	**0.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	28,720,487	28,367,656	352,831	1.2%
Acute Fee for Service Payments:				
Hospital Services	622,033,226	604,431,405	17,601,821	2.8%
Behavioral Health	11,601,238	10,824,931	776,307	6.7%
Physicians	222,741,531	210,739,484	12,002,047	5.4%
Dentists	82,517,969	80,570,999	1,946,970	2.4%
Other Practitioners	31,921,344	27,583,996	4,337,349	13.6%
Home Health Care	19,979,100	19,397,353	581,747	2.9%
Lab & Radiology	20,323,035	19,510,542	812,493	4.0%
Medical Supplies	37,128,088	36,809,775	318,313	0.9%
Ambulatory/Clinics	171,834,446	162,414,053	9,420,393	5.5%
Prescription Drugs	415,575,002	410,099,381	5,475,621	1.3%
OHCA Therapeutic Foster Care	253,634	273,037	(19,403)	(7.6)%
Other Payments:				
Nursing Facilities	418,129,252	367,134,242	50,995,010	12.2%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	40,067,388	38,728,151	1,339,237	3.3%
Medicare Buy-In	115,458,810	115,665,012	(206,202)	(0.2)%
Transportation	49,159,847	47,798,069	1,361,778	2.8%
Money Follows the Person-OHCA	123,297	132,177	(8,880)	(7.2)%
Electronic Health Records-Incentive Payments	35,454	35,454	-	0.0%
Part D Phase-In Contribution	40,304,678	40,747,517	(442,839)	(1.1)%
Supplemental Hospital Offset Payment Program	355,583,962	355,583,962	-	0.0%
Telligen	6,694,875	6,709,185	(14,310)	(0.2)%
Total OHCA Medical Programs	**2,690,186,663**	**2,583,556,380**	**106,630,283**	**4.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,812,370,275**	**$ 2,701,521,513**	**$ 110,848,762**	**3.9%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 151,288,580**	**$ 186,915,811**	**$ 35,627,232**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2021, For the Seven Month Period Ending January 31, 2021

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 28,476,031	$ 28,362,116	$ -	$ 108,375	$ -	$ 5,541	$ -
Inpatient Acute Care	757,407,620	382,176,619	283,901	4,198,174	277,224,739	676,042	92,848,145
Outpatient Acute Care	292,389,318	217,044,395	24,269	6,279,377	64,815,098	4,226,179	-
Behavioral Health - Inpatient	40,295,295	5,519,924	-	687,315	11,892,748	-	22,195,308
Behavioral Health - Psychiatrist	6,956,384	5,305,007	-	-	1,651,377	-	-
Behavioral Health - Outpatient	10,344,936	-	-	-	-	-	10,344,936
Behavioral Health-Health Home	9,572,983	-	-	-	-	-	9,572,983
Behavioral Health Facility- Rehab	122,287,436	-	-	-	-	81,468	122,287,436
Behavioral Health - Case Management	3,145,994	-	-	-	-	-	3,145,994
Behavioral Health - PRTF	7,436,512	-	-	-	-	-	7,436,512
Behavioral Health - CCBHC	67,554,066	-					67,554,066
Residential Behavioral Management	10,389,334	-	-	-	-	-	10,389,334
Targeted Case Management	34,542,213	-	-	-	-	-	34,542,213
Therapeutic Foster Care	273,037	273,037	-	-	-	-	-
Physicians	268,260,515	208,806,175	33,892	5,114,255	-	1,899,416	52,406,776
Dentists	80,664,514	80,564,748	-	93,515	-	6,252	-
Mid Level Practitioners	836,049	812,527	-	23,233	-	290	-
Other Practitioners	27,316,923	26,439,566	260,379	545,744	-	71,233	-
Home Health Care	19,404,151	19,385,613	-	6,798	-	11,740	-
Lab & Radiology	20,339,626	19,402,526	-	829,084	-	108,016	-
Medical Supplies	37,114,944	35,202,162	1,581,727	305,168	-	25,887	-
Clinic Services	167,088,428	158,334,753	-	2,874,053	-	144,126	5,735,496
Ambulatory Surgery Centers	4,139,891	3,928,491	-	204,717	-	6,683	-
Personal Care Services	5,786,787	-	-	-	-	-	5,786,787
Nursing Facilities	367,134,242	238,112,670	129,014,560	-	-	7,012	-
Transportation	47,705,974	45,751,736	1,612,196	216,552	-	125,490	-
IME/DME/GME	49,781,769	-	-	-	-	-	49,781,769
ICF/IID Private	38,728,151	31,804,047	6,924,104	-	-	-	-
ICF/IID Public	14,435,683	-	-	-	-	-	14,435,683
CMS Payments	156,412,529	156,170,346	242,184	-	-	-	-
Prescription Drugs	424,033,190	408,561,193	-	13,933,810	-	1,538,187	-
Miscellaneous Medical Payments	308,647	306,738	-	-	-	1,908	-
Home and Community Based Waiver	128,828,172	-	-	-	-	-	128,828,172
Homeward Bound Waiver	44,963,450	-	-	-	-	-	44,963,450
Money Follows the Person	132,177	132,177	-	-	-	-	-
In-Home Support Waiver	14,687,741	-	-	-	-	-	14,687,741
ADvantage Waiver	105,965,504	-	-	-	-	-	105,965,504
Family Planning/Family Planning Waiver	2,098,810	-	-	-	-	-	2,098,810
Premium Assistance*	33,783,545	-	-	33,783,544.94	-	-	-
Telligen	6,709,185	6,709,185	-	-	-	-	-
Electronic Health Records Incentive Payments	35,454	35,454	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,457,767,210**	**$ 2,079,141,204**	**$ 139,977,211**	**$ 69,203,715**	**$ 355,583,962**	**$ 8,935,472**	**$ 805,007,114**
			-	-	-	-	-

* Includes $33,440,627.09 paid out of Fund 245

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OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2021, For the Seven Month Period Ending January 31, 2021

REVENUE	FY21 Actual YTD
Revenues from Other State Agencies	$ 272,681,655
Federal Funds	595,024,190
TOTAL REVENUES	**$ 867,705,844**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	128,828,172
Money Follows the Person	-
Homeward Bound Waiver	44,963,450
In-Home Support Waivers	14,687,741
ADvantage Waiver	105,965,504
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	14,435,683
Personal Care	5,786,787
Residential Behavioral Management	6,065,308
Targeted Case Management	30,860,757
Total Department of Human Services	**351,593,402**
State Employees Physician Payment	
Physician Payments	52,406,776
Total State Employees Physician Payment	**52,406,776**
Education Payments	
Graduate Medical Education	-
Indirect Medical Education	36,950,916
Direct Medical Education	3,275,088
DSH	9,555,765
Total Education Payments	**49,781,769**
Office of Juvenile Affairs	
Targeted Case Management	1,447,493
Residential Behavioral Management	4,324,026
Total Office of Juvenile Affairs	**5,771,519**
Department of Mental Health	
Case Management	3,145,994
Inpatient Psychiatric Free-standing	22,195,308
Outpatient	10,344,936
Health Homes	9,572,983
Psychiatric Residential Treatment Facility	7,436,512
Certified Community Behavioral Health Clinics	67,554,066
Rehabilitation Centers	122,287,436
Total Department of Mental Health	**242,537,233**
State Department of Health	
Children's First	-
Sooner Start	613,455
Early Intervention	1,619,018
Early and Periodic Screening, Diagnosis, and Treatment Clinic	513,089
Family Planning	148,732
Family Planning Waiver	1,950,078
Maternity Clinic	-
Total Department of Health	**4,844,373**
County Health Departments	
EPSDT Clinic	204,233
Family Planning Waiver	-
Total County Health Departments	**204,233**
State Department of Education	**106,510**
Public Schools	**508,436**
Medicare DRG Limit	**81,472,668**
Native American Tribal Agreements	**4,404,719**
Department of Corrections	**2,574,627**
JD McCarty	**8,800,849**
Total OSA Medicaid Programs	**$ 805,007,114**
OSA Non-Medicaid Programs	**$ 73,618,308**
Total Other State Agencies	**$ 878,625,423**
Accounts Receivable from OSA	**$ 10,919,578**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2021, For the Seven Month Period Ending January 31, 2021

REVENUES		FY 21 Revenue
SHOPP Assessment Fee		118,801,652
SHOPP Assessment Fee - Expansion		1,704,564
Federal Draws	$	261,612,844
Interest		86,186
Penalties		-
State Appropriations		(22,650,000)
TOTAL REVENUES	$	359,555,246

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 21 Expenditures
Program Costs:	7/1/20 - 9/30/20	10/1/20 - 12/31/20	1/1/21 - 3/31/21	4/1/21 - 6/30/21		
Hospital - Inpatient Care	87,121,848	97,820,590	92,282,301		$	277,224,739
Hospital -Outpatient Care	20,307,378	22,294,727	22,212,993			64,815,098
Psychiatric Facilities-Inpatient	3,554,176	3,995,809	4,342,763			11,892,748
Rehabilitation Facilities-Inpatient	432,709	486,476	732,193			1,651,377
Total OHCA Program Costs	111,416,110	124,597,602	119,570,249	-	$	355,583,962
Total Expenditures					$	355,583,962

CASH BALANCE		
	$	3,971,284

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2021, For the Seven Month Period Ending January 31, 2021

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**47,101,450**	**$ 47,101,450**
*Quality of Care Penalties (*Non-Spendable Revenue)*	**166,164**	**$ 166,164**
Interest Earned	**22,834**	**22,834**
TOTAL REVENUES	**$ 47,290,447**	**$ 47,290,447**

EXPENDITURES	FY 21 Total $ YTD	FY 21 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 127,024,286	$ 33,929,872	
Eyeglasses and Dentures	143,093	$ 38,268	
Personal Allowance Increase	1,847,180	$ 492,934	
Coverage for Durable Medical Equipment and Supplies	1,581,727	$ 421,598	
Coverage of Qualified Medicare Beneficiary	602,441	$ 160,576	
Part D Phase-In	242,184	$ 242,184	
ICF/IID Rate Adjustment	3,119,164	$ 832,992	
Acute Services ICF/IID	3,804,941	$ 1,015,740	
Non-emergency Transportation - Soonerride	1,612,196	$ 430,147	
Total Program Costs	**$ 139,977,211**	**$ 37,564,312**	**$ 37,564,312**
Administration			
OHCA Administration Costs	$ 357,034	$ 178,517	
DHS-Ombudsmen	14,593	14,593	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 371,627**	**$ 193,110**	**$ 193,110**
Total Quality of Care Fee Costs	**$ 140,348,838**	**$ 37,757,421**	
TOTAL STATE SHARE OF COSTS			**$ 37,757,421**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2021, For the Seven Month Period Ending January 31, 2021

REVENUES	FY 20 Carryover	FY 21 Revenue	Total Revenue
Prior Year Balance	$ 16,831,479		
State Appropriations	-		
Federal Draws - Prior Year	254,424		
Total Prior Year Revenue			17,085,903
Tobacco Tax Collections	-	23,844,769	23,844,769
Interest Income	-	209,923	209,923
Federal Draws	-	24,528,644	24,528,644
TOTAL REVENUES	$ 17,085,903	$ 48,583,336	$ 65,669,239

EXPENDITURES		FY 20 Expenditures	FY 21 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 33,440,627	$ 33,440,627
	College Students/ESI Dental		342,918	91,667
Individual Plan				
	SoonerCare Choice		$ 105,111	$ 27,921
	Inpatient Hospital		4,154,624	1,107,395
	Outpatient Hospital		6,166,296	1,640,583
	BH - Inpatient Services-DRG		664,226	176,754
	BH -Psychiatrist		-	-
	Physicians		5,022,304	1,336,173
	Dentists		90,902	24,139
	Mid Level Practitioner		23,233	6,171
	Other Practitioners		537,599	143,068
	Home Health		6,798	1,815
	Lab and Radiology		808,815	215,216
	Medical Supplies		301,426	80,253
	Clinic Services		2,788,295	739,718
	Ambulatory Surgery Center		203,892	54,540
	Skilled Nursing		-	-
	Prescription Drugs		13,685,969	3,641,120
	Transportation		213,780	56,719
	Premiums Collected			(52,936)
Total Individual Plan			$ 34,773,270	$ 9,198,649
	College Students-Service Costs		$ 646,900	$ 172,093
Total OHCA Program Costs			$ 69,203,715	$ 42,903,036
Administrative Costs				
	Salaries	$ -	$ 1,259,771	$ 1,259,771
	Operating Costs	3,088	4,825	7,912
	E&E Development DXC	-	-	-
	Contract - DXC	273,666	585,424	859,090
Total Administrative Costs		$ 276,754	$ 1,850,020	$ 2,126,773
Total Expenditures				$ 45,029,809
NET CASH BALANCE		$ 16,809,149	$ 3,830,280.60	$ 20,639,430

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

SFY 2021, For the Seven Month Period Ending January 31, 2021

REVENUES	FY 21 Revenue	State Share
Tobacco Tax Collections	$ 475,859	$ 475,859
TOTAL REVENUES	**$ 475,859**	**$ 475,859**

EXPENDITURES	FY 21 Total $ YTD	FY 21 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,541	$ 1,172	
Inpatient Hospital	676,042	$ 143,536	
Outpatient Hospital	4,226,179	$ 886,201	
Inpatient Services-DRG	-	$ -	
Psychiatrist	-	$ -	
TFC-OHCA	-	$ -	
Nursing Facility	7,012	$ 1,571	
Physicians	1,899,416	$ 401,009	
Dentists	6,252	$ 1,336	
Mid-level Practitioner	290	$ 65	
Other Practitioners	71,233	$ 14,985	
Home Health	11,740	$ 2,506	
Lab & Radiology	108,016	$ 22,900	
Medical Supplies	25,887	$ 5,500	
Clinic Services	144,126	$ 30,340	
Ambulatory Surgery Center	6,683	$ 1,394	
Prescription Drugs	1,538,187	$ 323,979	
Transportation	125,490	$ 26,766.97	
Miscellaneous Medical	1,908	$ 374.53	
Total OHCA Program Costs	**$ 8,854,003**	**$ 1,863,635**	
OSA DMHSAS Rehab	81,468	17,249	
Total Medicaid Program Costs	**$ 8,935,472**	**$ 1,880,884**	
TOTAL STATE SHARE OF COSTS			**$ 1,880,884**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OHCA Monthly Metrics
May 2021
(March 2021 Data)

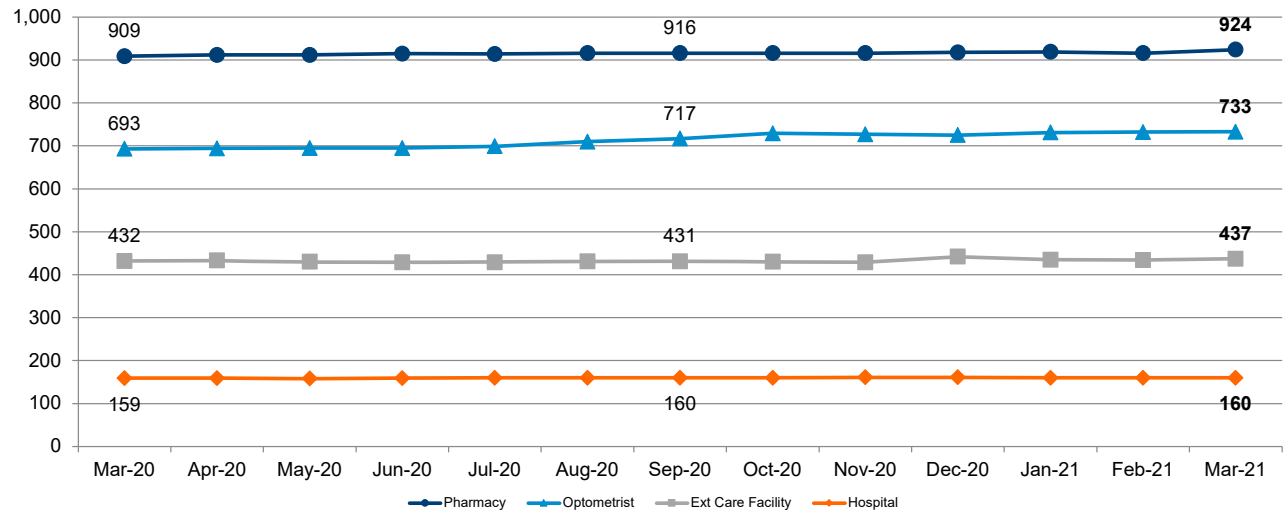
SOONERCARE ENROLLMENT/EXPENDITURES

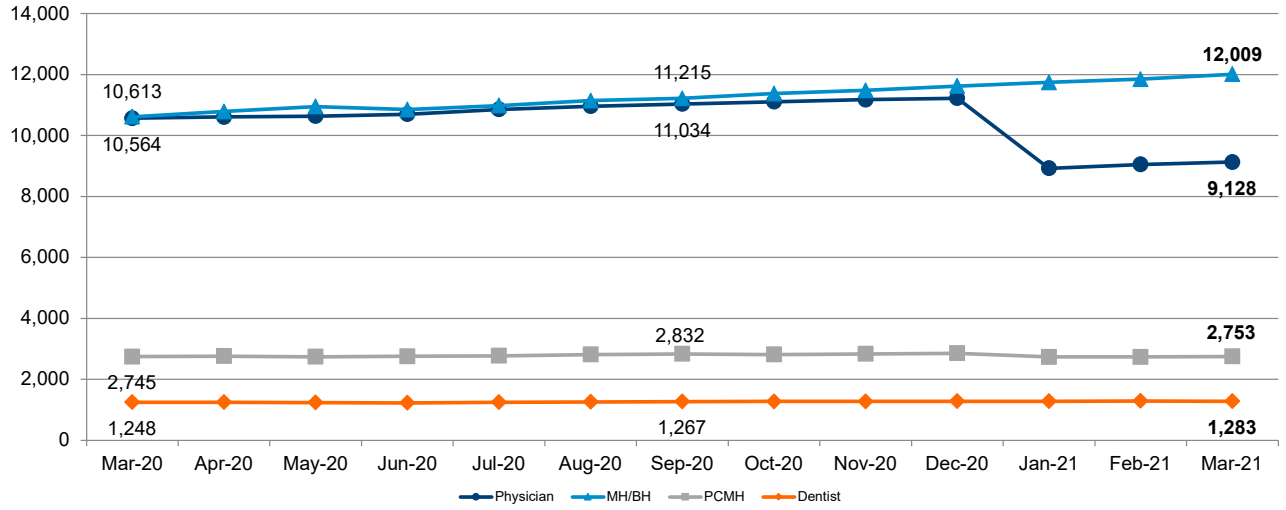
Delivery System			Enrollment March 2021	Children March 2021	Adults March 2021	Enrollment Change	Total Expenditures March 2021	PMPM March 2021
SoonerCare Choice Patient-Centered Medical Home			**627,096**	**509,659**	**117,437**	**5,515**	**$180,258,510**	
	Lower Cost	*(Children/Parents; Other)*	584,027	496,106	87,921	5,145	$122,478,360	$210
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,069	13,553	29,516	370	$57,780,150	$1,342
SoonerCare Traditional			**284,134**	**110,261**	**173,873**	**1,306**	**$225,118,501**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	163,485	105,312	58,173	883	$51,816,244	$317
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	120,649	4,949	115,700	423	$173,302,257	$1,436
Insure Oklahoma			**38,752**	**1,172**	**37,580**	**945**	**$13,667,534**	
	Employer-Sponsored Insurance		15,710	540	15,170	-70	$5,543,856	$353
	Individual Plan		23,042	632	22,410	1,015	$8,123,678	$353
SoonerPlan			**47,579**	**1,506**	**46,073**	**1,260**	**$270,978**	$6
TOTAL (UNDUPLICATED)			**997,544**	**622,598**	**374,963**	**9,026**	**$419,315,522**	

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

IN-STATE CONTRACTED PROVIDERS

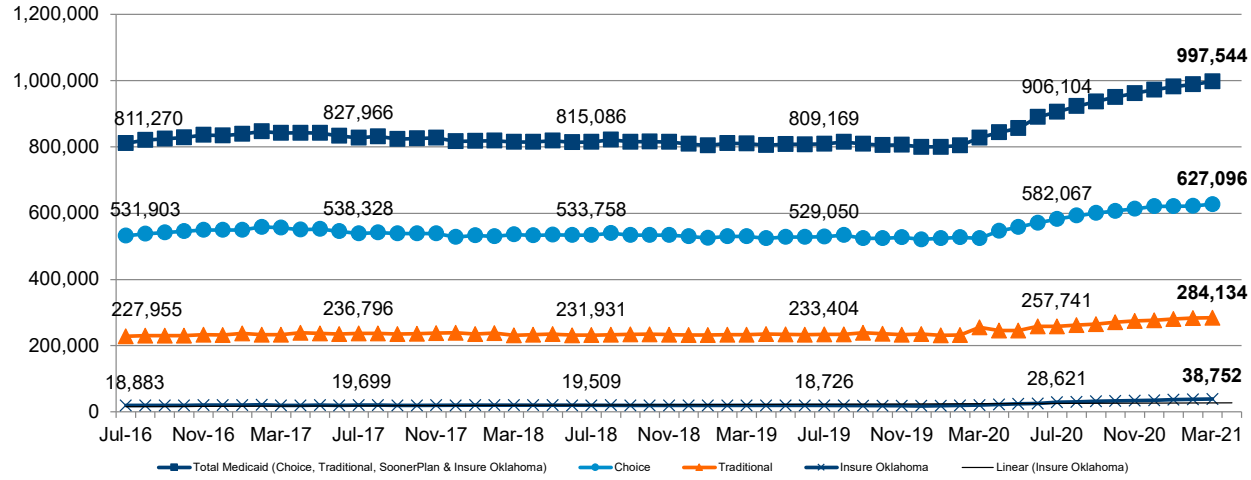
Total In-State Providers: 47,107 (+691) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

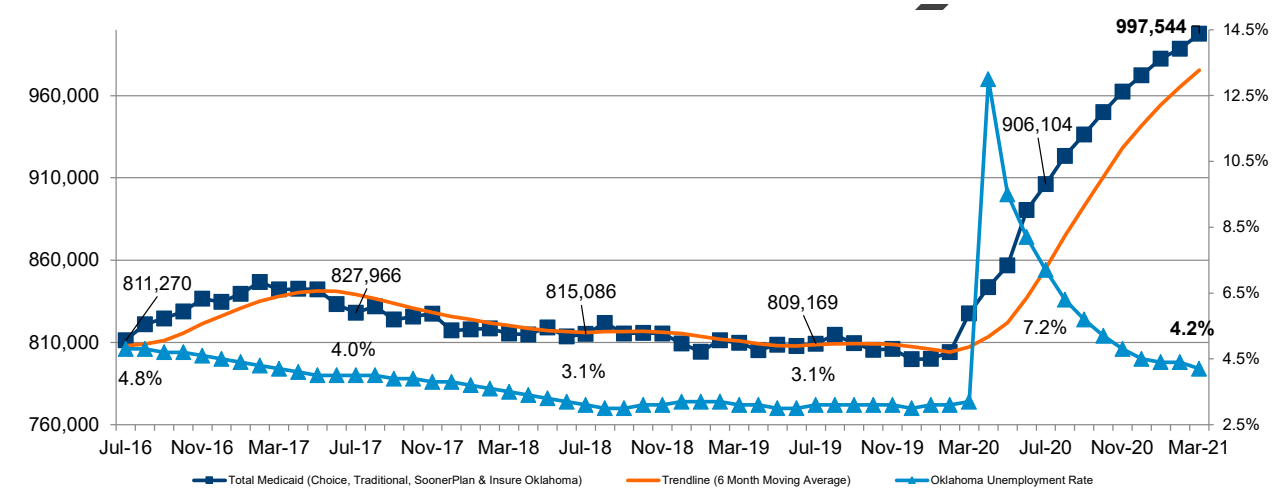




*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.
MH/BH is Mental Health and Behavioral Health providers. PCMH is Patient-Centered Medical Home (Choice) providers.

ENROLLMENT BY MONTH





Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on August 22, 2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds. Increase in March 2020 due to COVID-19 economic impact and relief measures (Continuity of care by postponing recertifications).

MAC PRESENTATION

Mike Herndon, DO
Chief Medical Officer
Oklahoma Health Care Authority

May 13, 2021

PERIPHERAL NERVE STIMULATION

NERVE STIMULATION

What is Peripheral Nerve Stimulation?

- Peripheral nerve stimulation involves the placement of electrodes on a selected peripheral nerve and an electrical current is sent through the electrode to block pain signals.
- Electrodes are connected by a wire to an implanted neurostimulator and a device similar to a remote control is used to control the level of electrical current that an individual will receive for pain management.
- Once the pain signal is blocked it can help relieve the pain.

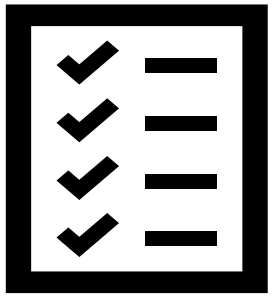
NERVE STIMULATION

- Prior to the permanent implantation of this device, a patient undergoes a trial stimulation that involves an electrode array being peripherally inserted close to the nerve and a neurostimulator device is kept on the outside of the body.
- If the trial is successful at relieving at least 50% of the individual's pain over a prescribed trial period, it is considered medically appropriate for permanent implantation of the neurostimulator device.

NERVE STIMULATION

- Currently, the permanent placement requires prior authorization, but the trial stimulation does not.
- All other nerve stimulator trial services require prior authorization.
- OHCA would like to place the peripheral vagal nerve trial stimulation on PA as well, in order to make sure members are appropriate candidates for this treatment.

APPROVAL CRITERIA



INDICATIONS

A. Prior to permanent Peripheral Nerve Stimulator implantation, a stimulation trial of peripheral nerve stimulation is considered medically necessary for the treatment of *chronic intractable pain* when ALL of the following criteria are met:

1. Documented chronic and severe pain for at least 3 months; AND
2. Documentation of failure to reasonable alternative therapies such as physical therapy, analgesics, anticonvulsants, muscle relaxants, antidepressants, topical anesthetics, and nerve blocks; AND
3. Lack of surgical contraindications including infections and medical risks; AND
4. No active substance abuse issues; AND
5. Psychological evaluation prior to trial implantation has been performed and indicates no contraindications to implantation.

B. Permanent peripheral nerve stimulator implantation may be considered medically necessary when ALL of the criteria above (A1 – 5) are met AND the stimulation trial of the device has provided greater than or equal to 50% reduction in pain intensity before permanent implantation.

SECTION 1115 INSTITUTIONS FOR MENTAL DISEASE (IMD) WAIVER

POST-AWARD FORUM

Melissa Miller, MSW, Director of Medicaid Behavioral Health Policy

Oklahoma Department of Mental Health and Substance Abuse Services

PURPOSE OF IMD WAIVERS

- Historically, federal regulations have prohibited Medicaid reimbursement for adult stays in facilities considered to be Institutions for Mental Disease, or IMDs.
- IMDs refer to facilities that primarily provide diagnosis, treatment or care to persons with behavioral health needs and have more than 16 beds.
- Through submission of a Section 1115 demonstration waiver of the IMD exclusion (IMD waiver), states can request Medicaid reimbursement for services provided in IMDs.
- States must show how coverage of these services will complement, but not replace, provision of services in less restrictive settings.
- State must also engage in an evaluation process that tests certain hypotheses.

OVERVIEW OF OKLAHOMA'S IMD WAIVER

- States can pursue an IMD waiver for mental health or substance use disorder treatment services.
- Oklahoma's IMD waiver application includes both categories of services through a joint Serious Mental Illness (SMI) and Substance Use Disorder (SUD) waiver.
- The waiver will be effective for five years from the date of approval, with a potential for renewal.
- Oklahoma's approval date is December 22, 2020.
- The SMI portion of the waiver was implemented immediately upon approval.
- The SUD portion of the waiver was implemented on January 18.

INCLUDED POPULATIONS AND SERVICES

Inpatient stays in psychiatric hospitals (with more than 16 beds).

- Adults ages 21-64.

Crisis stabilization services in crisis units (with more than 16 beds).

- Adults ages 18-64.

Substance use disorder treatment in residential settings (with more than 16 beds).

- Adults ages 18-64.
- Individuals under 18 years old.

CHALLENGES

- Length of stay requirements
  - State must achieve 30 day average length of stay across providers
  - Inpatient psychiatric stays over 60 days are not Medicaid compensable

- Waiver monitoring and reporting
  - State must report on approximately 75 metrics

- New Medicaid provider onboarding and enrollment

ACHIEVEMENTS

The waiver has helped the State achieve significant behavioral health delivery system achievements including:

- Streamlined, evidence-based, ASAM-aligned placement criteria for residential substance use disorder stays
- Evolved provider requirements to support evidence-based practices and goals of the waiver
    - Medication assisted treatment access in residential settings
    - Community Mental Health Center follow up within 72 hours
- More efficient use of tax-payer dollars
- Major policy barrier removed in anticipation of managed care and Medicaid expansion

Questions?

May MAC
Proposed Rules Amendment Summaries

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

APA WF # 21-02 State Plan Personal Care Services — The proposed rule revisions will revoke the State Plan Personal Care Services Eligible Provider Exception to comply with federal regulation. 42 Code of Federal Regulations (C.F.R.) § 440.167does not allow a legal guardian to provide personal care services. Additional revisions will align policy with current business practice and correct grammatical errors.

Budget Impact: Budget neutral

Tribal Consultation: March 2, 2021

APA WF # 21-03 Remove Reasonable Limits on Amounts for Necessary Medical and Remedial Care not Covered under the Oklahoma Medicaid State Plan — The proposed change will remove policy which set reasonable limitations on medical expenses not covered under SoonerCare from an individual's post-eligibility income and for determining the vendor payment for nursing facilities or for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The rules had been previously promulgated and approved but not yet implemented.

Budget Impact: Budget neutral

Tribal Consultation: March 2, 2021

APA WF # 21-05A&B Medicaid Expansion and Prosthetics and Orthotics Changes — The proposed changes will expand Medicaid eligibility for individuals defined by 42 C.F.R. § 435.119 (Expansion Adults). Additionally, the proposed changes will define Expansion Adult benefits, prior authorization requirements, and/or medically necessity criteria. Additional rule changes will be made to indicate that Expansion Adults will receive prosthetics and orthotics above the current limits to meet federal regulation requirements.

Budget Impact: The estimated budget impact for SFY2022 will be an increase in the total amount of $1,339,830,140 with $164,138,054 in state share.

Tribal Consultation: March 2, 2021

APA WF # 21-06 Insure Oklahoma (IO) Individual Plan (IP) and Timely Filing — The proposed changes reflect that IO IP members and IO Employer-Sponsored Insurance (ESI) members with incomes at or below 138% of the federal poverty level (FPL) will transition to and be provided services by the SoonerCare program under the Expansion Adult option. Additionally, proposed changes will remove references to the IO IP program as the program is being terminated, add new timely filing requirements for IO ESI subsidy payments, align and clarify policy with current practice, and correct grammatical errors.

Budget Impact: The budget impact is reflected in APA WF 21-05A&B.

Tribal Consultation: September 1, 2020 and March 2, 2021

APA WF # 21-07 Payments from Trusts for Clothing Expenses not Counted as Income - The proposed revisions update policy regarding trust accounts and countable income for aged, blind, and disabled (ABD) members. In accordance with amended Supplemental Security Income (SSI) rules, payments from the trust to the member or to a third party for the purpose of providing for the member's clothing needs are not countable income in determining Medicaid eligibility, thus requiring an update to OHCA rules.

Budget Impact: Budget neutral

Tribal Consultation: May 4, 2021

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

SUBCHAPTER 15. STATE PLAN PERSONAL CARE SERVICES

317:35-15-2. State Plan Personal care services

(a) Personal care is assistance to an individual in carrying out Activities of Daily Living (ADLs) or in carrying out Instrumental Activities of Daily Living (IADLs) directly related to the member's personal care needs to prevent or minimize physical health regression or deterioration. Personal care service requires a skilled nursing assessment of need, development of a care plan to meet identified personal care needs, care plan oversight, and periodic re-assessment and updating, of the care plan, when necessary. Personal care services do not include technical services, such as suctioning, tracheal care, gastrostomy-tube feeding or care, specialized feeding due to choking risk, application of compression stockings, bladder catheterization, colostomy irrigation, wound care, application of prescription lotions or topical ointments, range of motion exercises, or the operation of equipment of a technical nature, such as a patient lift or oxygen equipment.

(b) Personal care members may receive services in limited types of living arrangements. The specific living arrangements are set forth below.

(1) Personal care members are not eligible to receive services while residing in an institutional setting including, but not limited to, licensed facilities, such as a hospital, nursing facility, licensed residential care facility or licensed assisted living facility, or in an unlicensed institutional living arrangement, such as a room and board home or facility. Personal care may not be approved when the ~~client~~member lives in the personal care assistant's home except with the approval of Oklahoma Department of Human Services ~~(DHS)~~(OKDHS) Aging Services.

(2) ~~Additional living arrangements in which members~~Members may receive personal care services ~~are~~in the member's own home, apartment, or a ~~family~~family's or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit including a bathroom and food storage/preparation amenities in addition to bedroom/living space.

(3) For personal care members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive personal care services~~ for the period during which the member is a student~~.

(4) With prior approval of the ~~DHS~~OKDHS area nurse, personal care services may be provided in an educational or employment setting to assist the member to achieve vocational goals identified in the care plan.

(c) Personal care services may be provided by an individual employed by the member, referred to as an individual personal care assistant (IPCA) ~~or~~. Personal care services may be provided by a personal care assistant (PCA) who is employed by a home care agency, provided the home care agency is certified ~~to provide personal care services~~ and contracted with the Oklahoma Health Care Authority (OHCA) to provide personal care services. ~~DHS must determine an IPCA to be~~Before providing services, OKDHS determines if the IPCA is qualified to provide personal care services and not identified as ~~formal/informal~~formal or informal support for the member ~~before they can provide services~~. Persons eligible to serve as either IPCAs or ~~PCAS~~PCAs must:

(1) ~~be~~Be at least ~~18~~eighteen (18) years of age;

(2) ~~have~~Have no pending notation related to abuse, neglect, or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry;

(3) ~~not~~Not be included in the ~~DHS~~OKDHS Community Services Worker Registry;

(4) ~~not~~Not be convicted of a crime or have any criminal background history or registry listings that prohibit employment per ~~O.S. Title 63, Section 1-1950.1;~~Title 63 Oklahoma Statute Section 1-1950.1;

(5) ~~demonstrate~~Demonstrate the ability to understand and carry out assigned tasks;

(6) ~~not~~Not be a legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served~~, exceptions may be made for a legal guardian to provide services only with prior approval from DHS Aging Services~~;

(7) ~~have~~Have a verifiable work history ~~and/or~~or personal references, and verifiable identification; and

(8) ~~meet~~Meet any additional requirements outlined in the contract and certification requirements with OHCA.

(d) Eligibility for Personal Care is contingent on ~~an individual~~a member requiring one (1) or more of the services offered at least monthly that include personal care, meal preparation, housekeeping, laundry, shopping or errands, or specified special tasks to meet ADL or IADL assessed needs.

317:35-15-3. Application for State Plan Personal Care

(a) **Requests for Personal Care.** A request for Personal Care is made to the local OKDHS office or ADvantage Administration (AA). A written financial application is not required for an individual

who has an active SoonerCare case. A financial application for Personal Care is initiated when there is no active SoonerCare case. The application is signed by the applicant, parent, spouse, guardian or someone else acting on the applicant's behalf. All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes eligibility, the 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.

(b) **Date of application.**

(1) The date of application is:

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

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

(C) ~~the~~The date when the request for SoonerCare is made orally and the financial application form is signed later.

(2) An exception to paragraph (1) of this subsection would occur when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contract provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for SoonerCare eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) **Eligibility status.** Financial and medical eligibility must be established before services can be initiated.

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

(a) **Eligibility.** The Oklahoma Department of Human Services ~~(DHS)~~OKDHS 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 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~~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~~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~~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~~OKDHS nurse of potential risks and consequences, may be eligible.

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

(3) ~~have~~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~~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~~Lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and

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

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

(1) **"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;~~Bathing;

(B) ~~eating;~~Eating;

(C) ~~dressing;~~Dressing;

(D) ~~grooming;~~Grooming;

(E) ~~transferring~~Transferring includes activities such as getting in and out of a tub or bed to chair;

(F) ~~mobility;~~Mobility;

(G) ~~toileting;~~Toileting; and

(H) ~~bowel/bladder~~Bowel/bladder control.

(2) **"ADLs score of three or greater"** means the member cannot do at least one (1) ADL at all or needs some help with two (2) or more ADLs.

(3) **"Consumer support very low need"** means the member's UCAT Part III Consumer Support score is zero (0) 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) 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 fifteen (15) 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~~Care or support is required continuously with no relief or backup available;

(B) ~~informal~~Informal support lacks continuity due to conflicting responsibilities such as work or child care;

(C) ~~care~~Care or support is provided by persons with advanced age or disability; or

(D) ~~institutional~~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 twenty-five (25) 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,~~OKDHS per Section (§) 1025.1 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 43A O.S. § 10-103, involving a frail elderly, disabled person(s), or person(s) with developmental disabilities was made by ~~DHS~~OKDHS 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;~~Shopping;

(B) ~~cooking;~~Cooking;

(C) ~~cleaning;~~Cleaning;

(D) ~~managing~~Managing money;

(E) ~~using~~Using a phone;

(F) ~~doing~~Doing laundry;

(G) ~~taking~~Taking medication; and

(H) ~~accessing~~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 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 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.~~OKDHS. The medical decision for personal care is made by the ~~DHS~~OKDHS 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~~OKDHS 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~~OKDHS 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~~OKDHS county staff may initiate the UCAT, Part I.

(4) The ~~DHS~~OKDHS nurse is responsible for completing the UCAT Part III assessment visit within ~~ten-business (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~~OKDHS nurse completes the assessment visit within ~~twenty-business (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~~OKDHS 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~~OKDHS nurse informs the applicant of medical eligibility criteria and provides information about ~~DHS~~OKDHS long-term care service options. The ~~DHS~~OKDHS 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~~OKDHS 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~~OKDHS nurse informs the applicant of the other community long-term care service options. The ~~DHS~~OKDHS nurse assists the applicant in 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 services, the UCAT Part III assessment is done for all the household members at the same time.

(C) The ~~DHS~~OKDHS 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~~OKDHS nurse selects an agency from a list of all available agencies, using a round-robin system. The ~~DHS~~OKDHS nurse documents the name of the selected personal care provider agency.

(6) The ~~DHS~~OKDHS nurse completes the UCAT Part III and sends it to the ~~DHS~~OKDHS 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 ~~ninety-calendar (90-calendar)~~ninety (90) calendar days, a

new UCAT Part III and assessment visit is required.

(B) The ~~DHS~~OKDHS area nurse assigns a medical certification period of not more than 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 twelve (12) months and is provided by the ~~DHS~~OKDHS nurse.

(7) The ~~DHS~~OKDHS area nurse notifies the ~~DHS~~OKDHS county worker via 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~~OKDHS 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 (1-business)~~one (1) business day of provider agency acceptance, the ~~DHS~~OKDHS 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 (3-business)~~three (3) business days of receipt of the packet from the provider agency, the ~~DHS~~OKDHS 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 ~~ten-business (10-business)~~ten (10) business days of receipt of the SAM case from the ~~DHS~~OKDHS nurse, the ~~DHS~~OKDHS 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~~OKDHS nurse for further justification.

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

317:35-15-5. General financial eligibility requirements for State Plan Personal Care

Financial eligibility for Personal Care is determined using the rules on income and resources according to the eligibility group to which the individual is related. Income and resources are evaluated on a monthly basis for all individuals requesting payment for Personal Care who are categorically related to ABD; maximum countable monthly income and resource standards for individuals related to ABD are found on OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP program standards).

317:35-15-6. Determining financial eligibility of categorically

needy individuals

Financial eligibility for Personal Care for categorically needy individuals is determined as follows:

(1) **Financial eligibility for MAGI eligibility groups.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

(2) **Financial eligibility/categorically related to ABD.** In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. To be categorically needy, the countable income must be less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule VI (QMBP standard). If an individual and spouse cease to live together for reasons other than institutionalization or receipt of the ADvantage waiver or HCBW/MR services, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered.

(3) **Determining financial eligibility for State Plan Personal Care.** For individuals determined categorically needy for Personal Care, the member will not pay a vendor payment for Personal Care services.

317:35-15-7. Certification for State Plan Personal Care

(a) **Personal Care certification period.** The first month of the Personal Care certification period must be the first month the member was determined eligible for Personal Care, both financially and medically. When eligibility or ineligibility for Personal Care is established, the local office updates the computer-generated form and the appropriate notice is mailed to the member.

(b) **Financial certification period.** The financial certification period for Personal Care services is ~~12~~twelve (12) months. Redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical certification period.** A medical certification period of not more than thirty-six (36) months is assigned for an individual who is approved for Personal Care. The certification period for Personal Care is based on the Uniform Comprehensive Tool (UCAT) evaluation and clinical judgment of the Oklahoma Department of Human Services ~~(DHS)~~OKDHS area nurse or designee.

317:35-15-8. Agency State Plan personal care service authorization and monitoring

(a) Within ~~10-business~~ten (10) business days of receipt of the referral for personal care services, the personal care provider

agency nurse completes a Service Authorization Model (SAM) visit in the home to assess the member's personal care service needs, completes a SAM packet based on the member's needs and submits the packet to the ~~DHS~~OKDHS nurse. The member's SAM packet includes ~~DHS~~OKDHS Forms:

(1) 02AG044E, Personal Care Progress Notes;

(2) 02AG030E, Personal Care Planning Schedule/Service Plan; and

(3) 02AG029E, Personal Care Plan.

(b) When more than one (1) person in the household was referred to receive personal care or ADvantage services, all household members' SAM packets are discussed and developed with the eligible members so service delivery is coordinated to achieve the most efficient use of resources. The number of units of personal care service authorized for each individual is distributed between all eligible family members to ensure that the absence of one family member does not adversely affect the family member(s) remaining in the home. When one (1) or more persons in the same household with a personal care member were referred to or are receiving other formal services, such as ADvantage or Developmental Disability Services, then those services are coordinated as well.

(c) The personal care provider agency receives documentation from ~~DHS~~OKDHS as authorization to begin services. The agency delivers a copy of the care plan Form 02AG029E and the Personal Care Planning Schedule/Service Plan to the member upon initiating services.

(d) Prior to placing a personal care assistant (PCA) in the member's home or other service-delivery setting by the provider agency, an Oklahoma State Bureau of Investigation (OSBI) background check, an Oklahoma State Department of Health Registry check, and an ~~DHS~~OKDHS Community Services Worker Registry check must be completed per Sections 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes. Payment is made for PCAs who provide personal care services and meet criteria OAC 317:35-15-2(c)(1) 1 through 8).

(e) The provider agency nurse monitors the member's plan of care.

(1) The personal care provider agency contacts the member within ~~five-business~~five (5) business days of receipt of the authorized document in order to ensure services were implemented according to the authorized plan of care.

(2) The provider agency nurse makes a SAM home visit at least every six (6) months to assess the member's satisfaction with his or her care and to evaluate the SAM packet for adequacy of goals and authorized units. Whenever a home visit is made, the provider agency nurse documents findings in the Personal Care Progress Notes. The provider agency forwards a copy of the Progress Notes to the ~~DHS~~OKDHS nurse for review within ~~five-business~~five (5) business days of the visit. The monitoring

visit may be conducted by a Licensed Practical Nurse (LPN) only when the PCA is not performing hands-on personal care. A Registered Nurse (RN) must also co-sign the progress notes.

(3) Requests by the provider agency nurse to change the number of units authorized in the SAM packet are submitted to ~~(DHS)~~OKDHS and are approved or denied by the ~~(DHS)~~OKDHS area nurse or designee, prior to changed number of units~~ unit~~ implementation.

(4) Annually, or more frequently when the member's needs change, the provider agency nurse re-assesses the member's need's and develops a new SAM packet to meet the member's needs. The provider agency nurse conducts a home visit and completes and submits the annual reassessment documents to the ~~DHS~~OKDHS nurse no sooner than ~~60-calendar~~sixty (60) calendar days before the existing service plan end-date, and no later than ~~14-calendar~~fourteen (14) calendar days prior to service.

(5) When the member is unstaffed, the provider agency communicates with the member and makes efforts to re-staff. It is recommended the provider agency contacts unstaffed members weekly by phone to actively monitor the health and safety of the member and documents ongoing efforts to provide staff. When the member is unstaffed for ~~30-calendar~~thirty (30) days, the provider agency notifies the ~~DHS~~OKDHS nurse on Form 02AG032E, Provider Communication Form. The ~~DHS~~OKDHS nurse contacts the member and when the member chooses, initiates a transfer of the member to another provider agency that can provide staff.

317:35-15-8.1. Agency State Plan Personal Care services; billing, and problem resolution

The ADvantage Administration (AA) certifies qualified personal care provider agencies and facilitates the execution of the agencies' SoonerCare (Medicaid) contracts on behalf of the Oklahoma Health Care Authority (OHCA). OHCA checks the list of providers barred from Medicare/SoonerCare (Medicaid) participation to ensure that the personal care services agency is not listed.

(1) **Payment for State Plan personal care.** Payment for personal care services is made for care provided in the member's ~~"own home"~~own home or in other limited types of living arrangements, per ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-15-2(b)(1 through 4).

(A) **Use of provider agency.** To provide personal care services, an agency must be licensed by the Oklahoma State Department of Health, meet certification standards identified by the Oklahoma Department of Human Services ~~(DHS),~~(OKDHS), and possess a current SoonerCare (Medicaid) contract.

(B) **Reimbursement.** Personal care services payment on behalf

of a member is made according to the type of service and number of ~~units of~~ personal care ~~services~~services units authorized in the Service Authorization Model (SAM) packet.

(i) The amount paid to provider agencies for each unit of service is determined according to established SoonerCare (Medicaid) rates for the ~~Personal Care~~personal care services. Only authorized units contained in each eligible member's individual SAM packet are eligible for reimbursement. Provider agencies serving more than one personal care service member residing in the same residence ensure the members' SAM packets combine units in the most efficient manner to meet the needs of all eligible persons in the residence.

(ii) Payment for personal care services is for tasks performed in accordance per OAC 317:30-5-951 only when listed on an authorized plan of care. Payment for personal care skilled nursing service is made on behalf of the member for assessment/evaluation and associated service planning per SAM nursing visit.

(iii) Service time for personal care services is documented through the use of the Electronic Visit Verification System (EVV), previously known as Interactive Voice Response Authentication (IVRA) system, when services are provided in the home.

(2) **Issue resolution.**

(A) The provider agency provides a written copy of their grievance process to each member at the commencement of services. The written grievance process includes the name and phone number of a provider agency contact person who is responsible for responding to such complaints and grievances. When the member is dissatisfied with the Personal Care provider agency or the assigned PCA and has exhausted attempts to work with the Personal Care provider agency's grievance process without resolution, the member is referred to the ~~DHS~~OKDHS State Plan Care Unit to attempt to resolve the issue(s). The member has the right to appeal to OHCA per OAC 317:2-1-2.

(B) When a PCA performance issue is identified, provider agency staff conducts a counseling conference with the member and/or the PCA as appropriate. Provider agency staff counsels the PCA regarding problems with his/her performance.

(3) **Persons ineligible to serve as PCAs.** Payment from SoonerCare funds for personal care services may not be made to an individual who is a legally responsible family member of the member, such as a spouse, legal guardian, or parent of minor child, to whom he/she is providing personal care services~~ (exceptions may be made for~~

~~legal guardians with prior approval from the Department of Human Services/Aging Services (DHS/AS).~~

~~317:35-15-8.2. State Plan Personal Care Eligible Provider Exception~~

~~The Oklahoma Department of Human Services (OKDHS) Aging Services (AS) may authorize a member's legal guardian to be eligible for SoonerCare (Medicaid) reimbursement when he or she is hired by a home care provider agency as a personal care service provider. Authorization for a legal guardian as a provider requires the criteria in (1) though (4) of this Section and monitoring provisions to be met.~~

~~(1) Authorization for a legal guardian to be the member's care provider may occur only when the member is offered a choice of providers and documentation demonstrates:~~

~~(A) Another provider is not available; or~~

~~(B) The member's needs are so extensive that the legal guardian providing the care is prohibited from obtaining employment.~~

~~(2) The service must:~~

~~(A) Fall under the State Plan Personal Care (SPPC) program guidelines;~~

~~(B) Be necessary to avoid institutionalization;~~

~~(C) Be a service and/or support specified in the person-centered service plan;~~

~~(D) Be provided by a person who meets provider qualifications;~~

~~(E) Be paid at a rate that does not exceed what would be paid to a provider of a similar service and does not exceed what is allowed by Medicaid (SoonerCare) for the payment of personal care or personal assistance services; and~~

~~(F) Not be an activity the legal guardian would ordinarily perform or is responsible to perform.~~

~~(3) The legal guardian service provider complies with:~~

~~(A) Providing no more that forty (40) hours of services in a seven (7) calendar day period;~~

~~(B) Planned work schedules that must be available in advance for the member's home care agency. Variations to the schedule must be noted and supplied to the home care agency two (2) weeks in advance unless the change is due to an emergency;~~

~~(C) Utilization of the Electronic Visit Verification System (EVV) also known as the Interactive Voice Response Authentication (IVRA) system; and~~

~~(D) Being identified and monitored by the home care agency.~~

~~(4) The home care agency is required to submit a request and obtain approval for eligible provider exceptions to OKDHS AS prior to employing a legal guardian as a member's personal care~~

~~assistant (PCA). Eligible provider exceptions require the home care agency to:~~

~~(A) Provide monitoring and complete the Eligible Provider Exception Six Month Review document, when in the member's home completing the six-month Nurse Evaluation document in the Medicaid waiver information system; and~~

~~(B) Annually complete the Eligible Provider Exception Request and submit it with the annual Service Authorization Model (SAM) documentation no later than forty-five (45) calendar days prior to the previous eligible provider exception service authorization end date.~~

317:35-15-9. Redetermination of financial eligibility for State Plan Personal Care

The OKDHS county Social Services Specialist must complete a redetermination of financial eligibility before the end of the certification period. A notice is generated only if there is a change which affects the member's financial eligibility.

317:35-15-10. Redetermination of medical eligibility for ~~personal care~~State Plan Personal Care services

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

(b) **Recertification.** The ~~DHS~~OKDHS 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 thirty-six (36) months. Those members, who are younger than eighteen (18) years of age, are re-evaluated by the ~~DHS~~OKDHS 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~~OKDHS nurse submits the re-assessment to the ~~DHS~~OKDHS area nurse for recertification. Documentation is sent to the ~~DHS~~ area nurse no later than the ~~tenth-calendar (10th-calendar)~~tenth (10th) calendar day of the month in which the certification expires. When the ~~DHS~~OKDHS 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~~OKDHS within five (5) business days of identifying the assessed

need. The change is approved or denied by the ~~DHS~~OKDHS area nurse or designee, prior to implementation.

(d) **Voluntary closure of 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~~OKDHS nurse or ~~DHS~~OKDHS county Social Services Specialist completes and signs ~~DHS~~OKDHS Form 02AG038E, State Plan Personal Care/ADvantage Program Voluntary Withdrawal Request. The ~~DHS~~OKDHS nurse submits closure notification to the provider agency.

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

(f) **Financial ineligibility.** When the ~~DHS~~OKDHS determines a personal care services member does not meet SoonerCare financial eligibility criteria, the ~~DHS~~OKDHS office notifies the ~~DHS~~OKDHS area nurse to initiate the closure process due to financial ineligibility. Individuals determined financially ineligible for personal care services are notified by ~~DHS~~OKDHS in writing of the determination and of their right to appeal the decision. The ~~DHS~~OKDHS nurse submits closure notification to the provider agency.

(g) **Closure due to medical ineligibility.** Individuals determined medically ineligible for personal care services are notified by ~~DHS~~OKDHS 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~~Who are not hospitalized or in an extended medical care facility, the existing medical eligibility certification is

extended for a maximum ~~sixty-calendar (60-calendar)days~~sixty (60) calendar days from the date of the previous medical eligibility expiration date;

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

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

(4) ~~who~~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~~OKDHS State Plan Care Unit (SPCU) nurse of effective end date. The ~~DHS~~OKDHS SPCU nurse submits closure notification to the provider agency.

(h) **Termination of State Plan personal care services.**

(1) Personal care services may be discontinued when:

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

(B) ~~other~~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~~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.

(D) ~~the~~The member or family member fails to cooperate with Personal Care service delivery or to comply with Oklahoma Health Care Authority (OHCA) or ~~DHS~~OKDHS rules as supported by professional documentation;

(E) ~~the~~The member's health or safety is at risk as supported by professional documentation;

(F) ~~additional~~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 services;

(G) ~~the~~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~~The member refuses to select and/or accept the services of a provider agency or personal care assistant (PCA) for ~~ninety-consecutive (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.~~OKDHS. The ~~DHS~~OKDHS nurse reviews the documentation and submits it to the ~~DHS~~OKDHS area nurse for determination. The ~~DHS~~OKDHS nurse notifies the personal care provider agency or PCA and the local ~~DHS~~OKDHS 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.

317:35-15-13.1. Individual personal care assistant (IPCA) service management

(a) An Individual Personal Care Assistant (IPCA) may be utilized to provide personal care services when it is documented to be in the best interest of the member to have an IPCA or when there are no qualified personal care provider agencies available in the member's local area. Oklahoma Health Care Authority (OHCA) checks the list of providers barred from Medicare/Medicaid participation to ensure the IPCA is not listed.

(b) After personal care services eligibility is established and prior to implementation of personal care services using an IPCA, the ~~DHS~~OKDHS nurse reviews the care plan with the member and IPCA and notifies the member and IPCA to begin personal care services delivery. The ~~DHS~~OKDHS nurse maintains the original care plan and forwards a copy of the care plan to the selected IPCA and member within ~~one-business~~one (1) business day of receipt of approval.

(c) The ~~DHS~~OKDHS nurse contacts the member within ~~five-business~~five (5) business days to ensure services are in place and meeting the member's needs and monitors the care plan for members with an IPCA. For any member receiving personal care services utilizing an IPCA, the ~~DHS~~OKDHS nurse makes a home visit at least every six (6) months beginning within ~~90-calendar~~ninety (90) calendar days from the date of personal care service initiation. ~~DHS~~OKDHS assesses the member's satisfaction with his or her personal care services and evaluates the care plan for adequacy of goals and units allocated. Requests for changes in the units authorized in the care plan must be approved by the ~~DHS~~OKDHS area nurse or designee, prior to implementation of the changed number of units.

317:35-15-13.2. Individual personal care assistants (IPCA) provider contractor; billing, training, and problem resolution

While the Oklahoma Health Care Authority (OHCA) is the contractor authorized under federal law, the Oklahoma Department of Human Services ~~(DHS)~~OKDHS nurse initiates initial contracts with qualified individuals~~ for provision of~~to provide personal care services per Oklahoma Administrative Code (OAC) 317:35-15-2. ~~The~~OHCA is responsible for the IPCA contract renewal~~ for the IPCA is the responsibility of OHCA~~.

(1) **IPCA payment.** Payment for personal care services is made for care provided in the member's ~~"own home"~~own home or in other limited types of living arrangements per OAC 317:35-15-2(b)(1) through (4). Personal care may not be approved when the ~~client~~member lives in the Personal Care Assistant's ~~(PCA's)~~(PCA) home, except with the approval of ~~DHS~~OKDHS Aging Services.

(A) **Reimbursement.** Personal care payment for a member is made according to the number of personal care units~~ of service~~ identified in the service plan.

(i) The amount per unit~~ amounts~~ paid to individual contractors is determined according to the established rates. A service plan is developed for each ~~eligible individual~~member in the home and units of service are assigned to meet ~~the~~each member's needs~~ of each member~~. The service plans combine units in the most efficient manner to meet the needs of all eligible ~~persons~~members in the household.

(ii) From the total amounts billed by the IPCA in (i) of this subparagraph, the OHCA, acting as agent for the member-employer, withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To ensure the individual contractor's Social Security account ~~may be~~is properly credited, ~~it is vital that~~ the individual contractor's Social Security number ~~be~~is entered correctly on each claim.

(iii) The contractor payment fee covers all personal care services included on the service and care plans developed by the ~~DHS~~OKDHS nurse. Payment is only made for eligible member's direct services and care~~ of the eligible member(s) only~~. The OKDHS area nurse, or designee, authorizes the number of units of service units the member receives.

(iv) A member may select more than one IPCA. This may be necessary as indicated by the service and care plans.

(v) The IPCA may provide SoonerCare personal care services for several households during one (1) week as

long as the daily number of paid service units does not exceed eight (8) hours, ~~32~~thirty-two (32) units per day. The total number of hours per week cannot exceed ~~40, 160 units.~~forty (40), one-hundred and sixty (160) units.

(B) **Release of wage ~~and/or~~or employment information for IPCAs.** Any inquiry received by the local office requesting wage ~~and/or~~or employment information for an IPCA is forwarded to~~ the~~ OHCA, Claims Resolution.

(2) **IPCA member selection.** Members ~~and/or~~or family members recruit, interview, conduct reference checks, and select the individual for IPCA consideration. Prior to placing a personal care service provider in the member's home, an ~~OSBI~~Oklahoma State Bureau of Investigation background check~~, a DHS~~and an OKDHS Community Services Worker Registry check must be completed per Section 1-1944 through 1-1948 of Title 63 of the Oklahoma Statutes~~.~~ (O.S. 63 §§ 1-1944 through 1-948). The ~~DHS~~OKDHS nurse must also check the Certified Nurse Aide Registry. The ~~DHS~~OKDHS nurse must affirm that the applicant's name is not contained on any of the registries. The ~~DHS~~OKDHS nurse notifies OHCA when the applicant is on ~~the Registry.~~any registry.

(A) **Persons eligible to serve as IPCAs.** Payment is made for personal care services to IPCAs ~~who~~and provide personal care services who meet the criteria per OAC 317:35-15-2(c)(1) through (8).

(B) **Persons ineligible to serve as IPCAs.** Payment from SoonerCare funds for personal care services may not be made to an individual who is a legally responsible family member, such as a spouse, legal guardian, or parent of a minor child of the member being served~~, exceptions to legal guardian are made only with prior approval from Aging Services Division~~.

(i) Payment cannot be made to ~~a DHS or~~ an OKDHS or OHCA employee. Payment cannot be made to an immediate family member of a ~~DHS~~an OKDHS employee who works in the same county without ~~DHS~~OKDHS Aging Services approval. When a family member relationship exists between ~~a DHS~~an OKDHS nurse and an IPCA in the same county, the ~~DHS~~ OHS OKDHS nurse cannot manage services for a member whose IPCA is a family member of the ~~DHS~~OKDHS nurse.

(ii) If it is determined that ~~an a DHS~~ an OKDHS or an OHCA employee is interfering in the process of providing services for personal or family benefit, ~~he or she~~the employee is subject to disciplinary action.

(3) **IPCA orientation.** When a member selects an IPCA, the ~~DHS~~OKDHS nurse ~~contacts~~notifies the~~ individual~~ selected IPCA to report to the county office to complete the Oklahoma State Department of Health~~ form~~(OSDH) Form 805, Uniform Employment

Application for Nurse Aide Staff, and the ~~DHS~~OKDHS Form 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation~~.~~ determination. For personal care members, this process is the responsibility of the ~~DHS~~OKDHS nurse. The IPCA can begin work when:

(A) ~~he or she was interviewed~~Interviewed by the member~~,~~;

(B) ~~he or she was oriented~~Orientated by the OKDHS nurse~~,~~;

(C) ~~he or she executed a~~A contract (OHCA-0026) is executed with the OHCA~~,~~;

(D) ~~the~~The effective service date ~~was~~is established~~,~~;

(E) ~~all~~All registries ~~were~~are checked and the IPCA's name is not listed~~,~~;

(F) ~~the Oklahoma State Department of Health~~OSDH Nurse Aide Registry ~~was~~is checked and no notations ~~were~~are found~~,~~; and

(G) ~~the~~ OSBI background check ~~was~~is completed.

(4) **Training of IPCAs.** It is the responsibility of the ~~DHS~~OKDHS nurse to make sure the IPCA has the training needed to carry out the plan of care prior to service initiation for each member.

(5) **Problem resolution related to the performance of the IPCA.** When it comes to the attention of the ~~DHS~~OKDHS nurse that there is a problem related to the IPCA's performance ~~of the IPCA~~, a counseling conference is held between the member, OKDHS nurse, and ~~worker.~~IPCA. The ~~DHS~~OKDHS nurse counsels the IPCA regarding problems with his or her performance. Counseling is considered when staff believes counseling will result in improved performance.

(6) **Termination of the IPCA Provider Agreement.**

(A) A recommendation for the termination of an IPCA's contract is submitted to OHCA and IPCA services are suspended immediately when~~:~~ the:

(i) ~~an~~ IPCA's performance is such that ~~his or her~~ continued participation in the program could pose a threat to the health and safety of the member or others; or

(ii) ~~the~~ IPCA failed to comply with the expectations outlined in the PCA Provider Agreement, and counseling is not appropriate or was not effective; or

(iii) ~~an~~ IPCA's name appears on the ~~DHS~~OKDHS Community Services Worker Registry, any of the registries listed in ~~Section 1-1947 of Title~~O.S. 63 ~~of the Oklahoma Statutes,~~§ 1-1947, even ~~though his or her name may not have appeared on the Registry~~when his or her name was not on a registry at the time of application or hiring.

(B) The ~~DHS~~OKDHS nurse makes the recommendation for the termination of the IPCA to ~~DHS~~OKDHS Aging Services who notifies the OHCA Legal Division of the recommendation. When

the problem is related to allegations of abuse, neglect, or exploitation, ~~DHS~~OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, OHCA, and the Oklahoma State Department of Health are notified by the ~~DHS~~OKDHS nurse.

(C) When the problem is related to allegations of abuse, neglect, or exploitation the ~~DHS~~OKDHS nurse follows the process, ~~as outlined in~~per OAC 340:100-3-39.

317:35-15-14. Billing procedures for State Plan personal care

Billing procedures for personal care 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). Contractors for Personal Care bill on CMS-1500 claim form. OHCA provides instructions to an Individual personal care assistant (IPCA) contracted provider for completion of the claim at the time of the contractor orientation. The contracted provider submits a claim for each member. The contracted provider prepares claims for services provided and submits the claims to the fiscal agent responsible for ensuring claims were properly completed. All personal care contractors must have a unique provider number. New contracted providers are mailed the provider number after they are placed on the claims processing contractor's provider file. All services provided in the service recipients home, member's home including Personal Care and Nursing must be documented through the Electronic Visit Verification (EVV) system. Additionally, work completed in the provider's office is documented in the EVV system. The EVV system provides alternate backup solutions if the automated system is unavailable; however, in the event of an EVV system failure, the provider documents time in accordance with internal policy and procedures backup plan. This documentation is sufficient to account for both in-home and in-office services. The provider agency's backup procedures are only permitted when the EVV system is unavailable.

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

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

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-68. Determining financial eligibility for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (public and private), for HCBW/IID services, and for persons age sixty-five (65) or older in mental health hospitals

(a) **Determining financial eligibility for care in an ICF/IID.** Financial eligibility and spenddown for individuals in an ICF/IID is determined according to whether or not a spouse remains in the home.

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

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

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

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

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ICF/IID services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ICF/IID services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated

over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

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

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse

income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

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

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

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

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for ICF/IID care. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/IID, receives ADvantage or HCBW/IID services, or is sixty-five (65) or older and in a mental health hospital to be eligible for ICF/IID services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/IID services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the

first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/IID services.** When an individual and spouse are separated due to the individual entering an ICF/IID, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the ICF/IID, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

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

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

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

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

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

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource

eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the ICF/IID. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the ICF/IID, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the ICF/IID.

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

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

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the effective date of certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the

institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the ICF/IID.

(vii) The resources determined for the individual in the ICF/IID cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into an ICF/IID, that amount is used when determining resource eligibility for a subsequent SoonerCare application for ICF/IID.

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

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

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

(III) Determination of the spousal share of resource;

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

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

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

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an ICF/IID on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned

resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse does not affect the eligibility of the spouse in the ICF/IID.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in an ICF/IID, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one (1) month's vendor payment, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) **Determination of the vendor payment for ICF/IID.** Calculation of the vendor payment after financial eligibility for care in an ICF/IID has been established is determined according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/IID services are considered community spouses. ~~The formula for determining the vendor payment for individuals without a spouse or other dependents is in accordance with OAC 317:35-19-21(b).~~

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

(A) Countable income;

(B) Minus the institutional or own home standard; and

(C) Minus the verified countable medical expenses (only the actual monthly payments being made for medical insurance premiums including Medicare premiums).

(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two. This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the

institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/MR services, is:

(A) Determine the institutionalized spouse's monthly income as described in (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than one dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

(c) **Determining financial eligibility for HCBW/IID.** For individuals determined eligible for HCBW/IID services, there is no vendor payment. Financial eligibility for HCBW/IID services for a single individual is determined the same as for ICF/IID services as outlined in paragraph (a)(1) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/IID services for an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital is

determined the same as for ICF/IID services as outlined in paragraph (a)(2) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/IID services for an individual with a spouse in the home who does not receive ADvantage or HCBW/IID services is determined the same as for an individual with a community spouse according to paragraph (a)(3) of this Section. If the individual is a minor child who can be determined categorically needy and SSP eligible by considering the parent(s)' income and resources in the deeming process, the case is handled in the usual manner. If the child is not eligible for SSP only because of the deeming of parent(s)' income/resources, financial eligibility for HCBW/IID services is determined using only the child's income/resources and exempting the parent(s)' income and resources from the deeming process.

(d) **Determining financial eligibility for persons age sixty-five (65) years or older in mental health hospitals.** The eligibility determination for an individual age sixty-five (65) or older in a mental health hospital as categorically needy is the same as for any other person who is institutionalized. (Refer to subsection (a) in this Section.) The same procedure for determining excess income to be applied to the vendor payment as described in this Section is applicable.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-21. Determining financial eligibility for care in nursing facility

(a) Financial eligibility and vendor payment calculations for individuals in a nursing facility (NF) are determined according to whether or not a spouse remains in the home.

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

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

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

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

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in Oklahoma Department of Human Services (OKDHS) Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for NF services. If the individual's gross

income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [Oklahoma Administrative Code (OAC) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF care has been determined, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCWB/IID services, or is sixty-five (65) or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources

of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/IID, or who receives ADvantage or HCBW/IID services, or is sixty-five (65) or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization for determination of financial eligibility. See (b) of this Section for post-eligibility calculation of the vendor payment and the community spouse income allowance, if applicable. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

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

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

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

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., to be eligible for Nursing Facility services. If the individual's gross income exceeds this standard, refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/IID, receives ADvantage or HCBW/IID services, or is sixty-five (65) or older and in a mental health hospital to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard for an individual listed in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF services has been determined, the spenddown calculation is used to compute the vendor payment. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's

share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one (1) month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/IID services.** When an individual and spouse are separated due to the individual entering an NF, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the NF, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

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

(i) If payment of income is made solely to one (1) or the other, the income is considered available only to that individual.

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

(iii) If payment of income is made to either one (1) or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no

interest is specified.

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

(v) If the individual's gross income exceeds the categorically needy standard as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. B. 1., refer to SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the NF. OKDHS Form 08MA011E, Assessment of Assets, is used for the assessment prior to application for SoonerCare. The amount determined as the spousal share is used for all subsequent applications for SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for SoonerCare is made at the same time the individual enters the NF, OKDHS Form 08MA012E, Title XIX Worksheet, is used in lieu of OKDHS Form 08MA011E.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the NF.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the Oklahoma Health Care Authority (OHCA), is found on OKDHS Form 08AX001E (Appendix C-1), Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one (1) year of the effective date of

certification for SoonerCare. At the first redetermination of eligibility, the worker must document that the resources have been transferred. After the first year of SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

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

(vi) When determining eligibility for SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the NF.

(vii) The resources determined above for the individual in the NF cannot exceed the maximum resource standard for an individual as shown in OKDHS Form 08AX001E (Appendix C-1), Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into NF, that amount is used when determining resource eligibility for a subsequent SoonerCare application for NF.

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

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

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

(III) Determination of the spousal share of resource;

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

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

(x) The rules on determination of income and resources are applicable only when an individual has entered an NF and is likely to remain under care for thirty (30) consecutive days. The thirty (30) day requirement is

considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the thirty (30) day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an NF on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse do not affect the eligibility of the spouse in the NF.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As SoonerCare is the payer of last resort, the full amount of the member's share of the vendor payment must first be applied to the facility's charges before SoonerCare reimbursement begins. See (b) of this Section for calculation of the vendor payment after financial eligibility has been determined.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one (1) month's vendor payment, certification is delayed up to thirty (30) days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) Calculation of the vendor payment after financial eligibility for care in a NF has been determined is performed according to whether or not a spouse remains in the home. For the purpose of calculating the community spouse income allowance, spouses receiving ADvantage or HCBW/IID services are considered community spouses.

(1) The formula for determining the vendor payment for individuals without a spouse or other dependents is:

(A) Countable income;

(B) Minus the institutional or own home standard; and

(C) Minus the verified countable medical expenses (only the

actual monthly payments being made for medical insurance premiums including Medicare premiums)~~;~~.~~ and~~

~~(D) Minus incurred expenses for necessary medical and remedial care not covered under Medicaid, as set forth in the Oklahoma State Medicaid Plan.~~

~~(i) In order to be allowed to be deducted, expenses must:~~

~~(I) Have been incurred during the three (3) month period immediately preceding the month of application;~~

~~(II) Have been prescribed by a medical professional;~~

~~(III) Be certified as being medically necessary by a treating physician, physician assistant, or advanced practice registered nurse working within the scope of his or her licensure; and~~

~~(IV) Be no more than the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Oklahoma.~~

~~(ii) The following expenses are not allowed to be deducted:~~

~~(I) Expenses incurred as the result of the imposition of a transfer penalty;~~

~~(II) Expenses for which a third party (including Medicaid) is liable, even if provided by an out-of-state network provider;~~

~~(III) Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary;~~

~~(IV) Expenses that had been the subject of a prior authorization denial by Medicaid, due to lack of medical necessity; and~~

~~(V) Health insurance premiums paid by an individual who is not a financially responsible relative, for which repayment is not expected.~~

(2) The own home standard is the categorically needy standard found on OKDHS Form 08AX001E (Appendix C-1), Schedule VI.

(3) The computation for the community spouse's share of resources for individuals with a spouse remaining in the home is the total countable resources divided by two (2). This amount cannot exceed the maximum resource standard. If it is less than the minimum resource standard, resources are deemed from the institutionalized spouse to the community spouse, up to the minimum standard.

(4) The formula for determining the vendor payment for an individual with a spouse remaining in the home, regardless of whether the spouse receives ADvantage or HCBW/IID services, is:

(A) Determine the institutionalized spouse's monthly income

as described in Paragraph (b)(1) of this Section.

(B) Determine how much of the institutionalized spouse's income can be deemed to the community spouse:

(i) Subtract the community spouse's gross income from the maximum monthly income standard on OKDHS Form 08AX001E (Appendix C-1), Schedule XI.

(ii) The resulting amount is the maximum amount that can be deemed from the institutionalized spouse to the community spouse.

(C) The amount actually deemed from the institutionalized spouse to the community spouse is subtracted from the institutionalized spouse's monthly income as described in Paragraph (b)(1) of this Section. Any amount remaining is the vendor payment if there are no minor dependent children, parents, or siblings residing with the community spouse.

(D) If there are minor dependent children, parents, or siblings residing with the community spouse, the formula for determining their allowance is:

(i) Divide the maximum monthly income standard from OKDHS Form 08AX001E (Appendix C-1), Schedule XI by 3;

(ii) Subtract the gross income of each dependent child, parent, or sibling residing with the community spouse from the amount in (i);

(iii) If there is more than one (1) dependent, add the amounts from (ii) together;

(iv) This amount is deemed to the dependents residing with the community spouse.

(E) The amount actually deemed to the dependents residing with the community spouse is subtracted from the amount determined in Subparagraph (b)(4)(C) of this Section. Any amount of the institutionalized spouse's income remaining is the vendor payment.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 1. GENERAL PROVISIONS

317:30-1-4. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"Expansion Adult" means an individual defined by 42 Code of Federal Regulations § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not categorically related to the aged, blind, or disabled.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-1. Creation and implementation of rules; applicability

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the ~~Oklahoma Health Care Authority~~OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, ~~the Deputy Administrator for Health Policy~~the Deputy State Medicaid Director, the ~~Medicaid Operations~~ State Medicaid Director, OHCA Tribal partners and the ~~Advisory Committee on Medical Care for Public Assistance Recipients~~OHCA Medical Advisory Committee. The ~~Medicaid Operations~~ State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent ~~with regard to~~regarding proper payment of claims.

(b) Payment to practitioners under Medicaid is made for services clearly identifiable as personally rendered services performed on behalf of a specific ~~patient~~member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped.
(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. ~~Well patient~~Wellness examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.
(e) The scope of the medical program for eligible children is the same as for adults except as further set out under ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service guidelines.
(f) Services, provided within the scope of the Oklahoma Medicaid ~~Program~~program, shall meet medical necessity criteria. Requests by qualified providers for services in and of itself shall not constitute medical necessity. The ~~Oklahoma Health Care Authority~~OHCA shall serve as the final authority pertaining to all determinations of medical necessity. Service limits listed within OAC 317:30 can be exceeded for expansion adults, upon meeting medical necessity as determined by OHCA and in alignment with the Oklahoma State Plan. Physical therapy, occupational therapy and speech language pathology have hard limits, which are set at forty-five (45) cumulative visits - fifteen (15) visits of each therapy. Members must meet medical necessity criteria, prior authorization, and all other documentation requirements. Medical necessity is established through consideration of the following standards:

(1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records and other supporting records, evidence sufficient to justify the ~~client's~~member's need for the service;

(3) Treatment of the ~~client's~~member's condition, disease or injury must be based on reasonable and predictable health outcomes;

(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider;

(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and

(6) Services must be appropriate for the ~~client's~~member's age and health status and developed for the ~~client~~member to achieve, maintain, or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a ~~case by case~~case-by-case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this ~~part~~Part apply to all providers of service who participate in the program.

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general ~~SoonerCare coverage~~SoonerCare coverage guidelines for the categorically needy:

(1) ~~Inpatient hospital~~Inpatient hospital services ~~other than those provided in an institution for mental diseases~~.

(A) Adult coverage for ~~inpatient hospital~~inpatient hospital stays as described at ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or ~~free standing~~freestanding dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected ~~outpatient surgical~~outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified ~~hospital based~~hospital-based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services

furnished by rural health clinic.
(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
(9) Maternity clinic services.
(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the ~~agency's~~Agency's Medical Authorization Unit.
(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
(12) ~~Nursing~~Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
(13) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA ~~Child Health~~child-health services are outlined in OAC 317:30-3-65.2 through ~~317:30-3-65.4~~317:30-3-65.12.

(A) ~~Child health screening examinations~~EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
(C) Immunizations.
(D) Outpatient care.
(E) Dental services as outlined in OAC 317:30-3-65.8.
(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) ~~Outpatient psychological~~Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.

(J) ~~Inpatient psychiatric~~Inpatient psychiatric services as outlined in OAC ~~317:30-5-95~~317:30-5-94 through 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) ~~Inpatient hospital~~Inpatient hospital services.

(M) Medical supplies, equipment, appliances~~ and prosthetic devices beyond the normal scope of SoonerCare~~, orthotics and prosthetics.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a ~~nursing~~long-term care facility, ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services;

(B) Optometrists' services;

(C) Psychologists' services;

(D) Certified ~~Registered Nurse Anesthetists~~registered nurse anesthetists;

(E) Certified ~~Nurse Midwives~~nurse midwives;

(F) Advanced ~~Practice Nurses~~practice registered nurses; and

(G) Anesthesiologist ~~Assistants~~assistants.

(17) ~~Free-standing~~Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6)

prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) ~~unlimited~~Unlimited medically necessary monthly prescriptions for:

(i) ~~members~~Members under the age of twenty-one (21) years; and

(ii) ~~residents~~Residents of ~~nursing~~long-term care facilities or ICF/IID.

(B) ~~seven~~Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) ~~Home and Community Based Services Waivers (HCBS)~~home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of ~~durable medical equipment.~~medical supplies, equipment, and appliances.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.

(23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.

~~(23)~~(24) Standard medical supplies.

~~(24)~~(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

~~(25)~~(26) Blood and blood fractions for members when

administered on an outpatient basis.
~~(26)~~(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
~~(27)Nursing~~(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
~~(28)~~(29) Inpatient psychiatric facility admissions for members ~~under twenty-one (21)~~ are limited to an approved length of stay ~~effective July 1, 1992,~~ with provision for requests for extensions.
~~(29)~~(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
~~(30)~~(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.
~~(31) Nursing~~(32) Long-term care facility services for members under twenty-one (21) years of age.
~~(32)~~(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a ~~Registered Nurse~~registered nurse (RN).
~~(33) Part A deductible and Part B Medicare Coinsurance and/or deductible~~(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.
~~(34)~~(35) HCBS for the intellectually disabled.
~~(35)~~(36) Home health services ~~limited to~~can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th visit. The visits are limited to any combination of ~~Registered Nurse~~RN and nurse aide visits.
~~(36)~~(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC

317:30-3-57.1; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

~~(37)~~(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a ~~nursing~~long-term care facility (Alternative Disposition Plan - ADP).

~~(38)~~(39) Case management services for the chronically and/or ~~severely~~seriously mentally ill.

~~(39)~~(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.

~~(40)~~(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.

~~(41)~~(42) Early intervention services for children ages zero (0) to three (3).

~~(42)~~(43) Residential behavior management in therapeutic foster care setting.

~~(43) Birthing center services.~~

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

(45) HCBS for aged or physically disabled members.

(46) Outpatient ambulatory services for members infected with tuberculosis.

(47) Smoking and tobacco use cessation counseling for children and adults.

(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in I/T/Us Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

(50) Residential substance use disorder (SUD) services.

(50) Medication-assisted treatment (MAT) services.

(51) Diabetes self-management education and support (DSMES)

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

PART 17. MEDICAL SUPPLIERS

317:30-5-210.1. Coverage for adults

~~Coverage of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for adults is specified in OAC 317:30-5-211.1 through OAC 317:30-5-211.18.~~Coverage of medical supplies,

equipment, and appliances for adults complies with 42 Code of Federal Regulations (C.F.R.) § 440.70 and is specified in Oklahoma Administrative Code (OAC) 317:30-5-211.1 through OAC 317:30-5-211.19.

317:30-5-211.13. ~~Prosthetics and orthotics~~Orthotics and prosthetics

(a) Coverage of prosthetics for ~~adults~~non-expansion adults is limited to (1) home dialysis equipment and supplies, (2) nerve stimulators, (3) external breast prosthesis and support accessories, and (4) implantable devices inserted during the course of a surgical procedure. Prosthetics prescribed by an appropriate ~~medical~~qualified provider and as specified in this section are covered items for non-expansion adults. There is no coverage of orthotics for non-expansion adults.

(1) **Home dialysis.** Equipment and supplies are covered items for members receiving home dialysis treatments only.

(2) **Nerve stimulators.** Payment is made for transcutaneous nerve stimulators, implanted peripheral nerve stimulators, and neuromuscular stimulators.

(3) **Breast prosthesis, bras, and prosthetic garments.**

(A) Payment is limited to:

(i) ~~one~~One (1) prosthetic garment with mastectomy form every ~~12~~twelve (12) months for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(ii) ~~two~~Two (2) mastectomy bras per year; and

(iii) ~~one~~One (1) silicone or equal breast prosthetic per side every ~~24~~twenty-four (24) months; or

(iv) ~~one~~One (1) foam prosthetic per side every six months.

(B) Payment will not be made for both a silicone and a foam prosthetic in the same ~~12~~twelve (12) month period.

(C) Breast prostheses, bras, and prosthetic garments must be purchased from a Board Certified Mastectomy Fitter.

(D) A breast prosthesis can be replaced if:

(i) ~~lost~~Lost;

(ii) ~~irreparably~~Irreparable damaged (other than ordinary wear and tear); or

(iii) ~~the~~The member's medical condition necessitates a different type of item and the physician provides a new prescription explaining the need for a different type of prosthesis.

(E) External breast prostheses are not covered after breast reconstruction is performed except in instances where a woman with breast cancer receives reconstructive surgery following a mastectomy, but the breast implant fails or ruptures and circumstances are such that an implant

replacement is not recommended by the surgeon and/or desired by the member.

(4) **Prosthetic devices inserted during surgery.** Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(b) Orthotics and prosthetics are covered for expansion adults services when:

(1) Orthotics are medically necessary when required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserve or improve physical function.

(2) Prosthetics are medically necessary as a replacement for all or part of the function of a permanently inoperative, absent, or malfunctioning body part. The member shall require the prosthesis for mobility, daily care, or rehabilitation purposes.

(3) In addition, orthotics and prosthetics must be:

(A) A reasonable and medically necessary part of the member's treatment plan;

(B) Consistent with the member's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the member; and

(C) Of high quality, with replacement parts available and obtainable.

(b) Refer to Oklahoma Administrative Code (OAC) 317:30-5-211.1 for definitions of orthotics and prosthetics.

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics (RHC) for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for ~~one~~(1) encounter per member per day. Payment is also limited to four (4) visits per member per month. Refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four (4) visit limit for children under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Program (EPSDT). Additional preventive service exceptions include: obstetrical care and family planning.

(A) ~~**Obstetrical care.** A Rural Health Clinic~~An RHC should have a written contract with its physician, certified nurse midwife (CNM), advanced practice registered nurse (APRN), or physician assistant (PA) that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should

also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services. Obstetrical care is exempted from the four (4) visit limitation.

(i) If the clinic compensates the physician, ~~certified nurse midwife or advanced practice nurse~~CNM, or APRN to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, ~~certified nurse midwives, physician assistants, and advanced practice nurses~~CNMs, PAs, and APRNs (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits ~~do not count as one of the four RHC visits per month.~~ are exempted from the four (4) visit limitation.

~~(2)~~ (3) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of ~~a~~an RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for ~~under 21~~individuals under twenty-one (21) are subject to the same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently ~~CLIA~~Clinical Laboratory Improvement Amendments (CLIA) certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) ~~Durable medical equipment or medical supplies~~Medical supplies, equipment and appliances are not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the ~~Non-Qualified~~non-qualified (ineligible) provisions of OAC 317:35-5-25;

(9) ~~SoonerPlan family planning services;~~Family planning services;

(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare; and

(11) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

(2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240 and contracted with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency.

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

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

The following words and terms, when used in this Chapter, have the following meaning, unless the context clearly indicates otherwise:

"Acute Care Hospital" means an institution that meets the requirements defined in Section (') 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

(A) ~~is~~Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) ~~is~~Is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) ~~meets~~Meets the requirements for participation in Medicare as a hospital.

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as sixty-five (65) years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. ~~Effective January 1, 2014, children~~Children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Area nurse" means a registered nurse in the OKDHS Aging

Services Division, designated according to geographic areas who evaluates the Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the OHCA.

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the OHCA Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or **"related"** means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility

extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"County" means the Oklahoma OKDHS' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by OKDHS.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays eighty percent (80%) of the allowable charge. The remaining twenty percent (20%) is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Expansion adult" means an individual defined by 42 Code of Federal Regulations (C.F.R.) § 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not related to the aged, blind, or disabled.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the UCAT for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Ineligible Spouse" means an individual who is not eligible for Supplemental Security Income (SSI) but is the husband or wife of

someone who is receiving SSI.

"Local office" means the Oklahoma OKDHS' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 C.F.R. ' 436.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age sixty-five (65) or older and for those under age sixty-five (65) who have been receiving disability benefits under these programs for at least twenty-four (24) months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of eighteen (18).

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for

individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the OKDHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the OHCA that assists with the eligibility determination process.

~~**"OKDHS"** means the Oklahoma Department of Human Services.~~**"OKDHS"** means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the UCAT for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a twelve (12) month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The OHCA Provider Manual (OAC 317:30) contains information on covered

medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ~~ICF/IIDs~~Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or inpatient acute care hospital stays are expected to last not less than sixty (60) days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-2. Categorically related programs

(a) In order to be eligible for SoonerCare, an individual must first meet the description of a member eligibility group. For individuals related to the aged, blind, or disabled groups, categorical relationship is established using the same definitions of age, disability and blindness as used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is ~~a~~an SSA/SSI recipient in current payment status (including presumptive eligibility), a ~~TANF~~Temporary Assistance for Needy Families (TANF) recipient, an adoption assistance or kinship guardianship assistance recipient, or is under age nineteen (19), categorical relationship is automatically established. For individuals related to expansion adults the categorical relationship is established and defined by 42 Code of Federal Regulations (C.F.R.) § 435.119. Categorical relationship to the pregnancy group is established when the determination is made by medical evidence that the individual is or has been pregnant. ~~Effective January 1, 2014, verification~~Verification of pregnancy is only required if the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and postpartum periods for women in this pregnancy group; see Subchapter 22 of this Chapter for services for unborn children covered under Title XXI. For an individual age nineteen (19) or over to be related to the parent and caretaker relative group, the individual must have a minor dependent child. For an individual to

be related to the former foster care children group, the individual must not be eligible for the Title XIX pregnancy or parent or caretaker relative groups, must be aged ~~19-26~~nineteen (19) to twenty-six (26), and must have been receiving SoonerCare as a foster care child when he/she aged out of foster care in Oklahoma. There is no income or resource test for the former foster care children group. Categorical relationship to ~~Refugee~~refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer (BCC) ~~Treatment~~treatment program is established in accordance with ~~OAC 317:35-21~~Subchapter 21 of this Chapter. Categorical relationship for the SoonerPlan ~~Family Planning Program~~family planning program is established in accordance with OAC 317:35-5-8. Categorical relationship for pregnancy related benefits covered under Title XXI is established in accordance with ~~OAC 317:35-22~~Subchapter 22 of the Chapter. Benefits for pregnancies covered under Title XXI medical services are provided within the scope of the program during the prenatal, delivery and postpartum care when included in the global delivery payment. To be eligible for SoonerCare benefits, an individual must be related to one (1) of the following eligibility groups and as defined above in this Section:

(1) Aged;
(2) Disabled;
(3) Blind;
(4) Pregnancy;
(5) Children, including newborns deemed eligible;
(6) Parents and ~~Caretaker Relatives~~caretaker relatives;
(7) Refugee;
(8) ~~Breast and Cervical Cancer Treatment~~BCC treatment program;
(9) SoonerPlan ~~Family Planning Program~~family planning program;
(10) Benefits for pregnancies covered under Title XXI;
(11) Former foster care children; or
(12) Expansion adults.

(b) The Authority may provide SoonerCare to reasonable categories of individuals under age twenty-one (21).

(1) Individuals eligible for SoonerCare benefits include individuals between the ages of nineteen (19) and twenty-one (21):

(A) ~~for~~For whom a public agency is assuming full or partial financial responsibility who are in custody as reported by ~~the Oklahoma Department of Human Services (OKDHS)~~OKDHS and in foster homes, private institutions or public facilities; or

(B) ~~in~~In adoptions subsidized in full or in part by a public agency; or

(C) ~~individuals~~Individuals under age ~~twenty one~~twenty-one (21) receiving active treatment as inpatients in public

psychiatric facilities or programs if inpatient psychiatric services for individuals under age ~~twenty one~~twenty-one (21) are provided under the State Plan and the individuals are supported in full or in part by a public agency; or

(2) Individuals eligible for SoonerCare benefits include individuals between the ages of eighteen (18) and ~~twenty one~~twenty-one (21) if they are in custody as reported by OKDHS on their ~~18th~~eighteenth (18th) birthday and living in an ~~out of home~~out-of-home placement.

317:35-5-9. Determining the categorical relationship to expansion adults

(a) To be eligible for SoonerCare under expansion adults, individuals shall meet the following requirements:

(1) Are age nineteen (19) years or older, and under age sixty-five (65);

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B;

(4) Are not eligible for SoonerCare in another mandatory eligibility group under Oklahoma's Medicaid State Plan;

(5) Have household income that is at or below 133 percent of the federal poverty level (FPL) for their household size; and

(6) Meet general SoonerCare program eligibility requirements described in Oklahoma Administrative Code (OAC) 317:35, including but not limited to citizenship and residence requirements.

(b) An individual whose household's modified adjusted gross income (MAGI) exceeds the income standard for participation under the parent and caretaker relative group, including those eligible for transitional medical assistance per 317:35-6-64.1, may participate in expansion adults if:

(1) The individual resides with and assumes primary responsibility for the care of a child under nineteen (19) years of age; and

(2) The child is enrolled in SoonerCare or other minimum essential coverage, as described by the Affordable Care Act.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-48. Determination of income and resources for categorical relationship to expansion adults

Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to expansion adults. See Subchapter 6 of this Chapter for MAGI rules.

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-60. Application for SoonerCare; forms

(a) **Application.** An application for ~~Medical Services~~medical services consists of the ~~Medical Assistance Application~~SoonerCare application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. ~~Effective January 1, 2014, the~~The application form is available as an online application, as a paper form, and is available to be completed by telephone with the assistance of the agency.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant~~,~~ or have children or are applying for family planning services only. A ~~face to face~~face-to-face interview is not required. Only SoonerCare applications for women who are pregnant, and families with children and for family planning services—are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or OKDHS form 08MA005E for individuals who are pregnant~~,~~ or have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. ~~Effective October 1, 2013, an~~An application for SoonerCare may also be submitted through the Health Insurance Exchange.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification of a need for medical services. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare Application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and an application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within ~~20~~twenty (20) days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within ~~20~~twenty (20) days by a signed application for SoonerCare.

317:35-5-63. Agency responsible for determination of eligibility

(a) **Determination of eligibility by Oklahoma Health Care Authority (OHCA).** OHCA is responsible for determining eligibility for the following eligibility groups:

(1) ~~children~~Children;

(2) ~~newborns~~Newborns deemed eligible;

(3) ~~pregnant~~Pregnant women;

(4) ~~pregnancy-related~~Pregnancy-related services under Title XXI;

(5) ~~parents~~Parents and caretaker relatives;

(6) ~~former~~Former foster care children;

(7) ~~Oklahoma Cares Breast~~ and Cervical Cancer ~~program~~(BCC) treatment program;

(8) SoonerPlan ~~Family Planning~~family planning program.

(9)Programs of All-Inclusive Care for the Elderly (PACE); and

(10) Expansion adults.

(b) **Determination of eligibility by ~~DHS~~OKDHS.** ~~DHS~~OKDHS is responsible for determining eligibility for the following eligibility groups:

(1) TANF recipients

(2) ~~recipients~~Recipients of adoption assistance or kinship guardianship assistance;

(3) ~~state~~State custody;

(4) Refugee ~~Medical Assistance~~medical assistance;

(5) ~~aged~~Aged;

(6) ~~blind~~Blind;

(7) ~~disabled~~Disabled;

(8) Tuberculosis;

(9) ~~QMBP~~Qualified Medicare Beneficiary Plus (QMBP);

(10) ~~QDWI~~Qualified Disabled Working Individual (QDWI);

(11) ~~SLMB~~Specified Low-Income Medicare Beneficiary (SLMB);

(12) ~~QI-1~~Qualifying Individual (QI-1);
(13) ~~Long term~~Long-term care services; and
(14) ~~alien~~Alien emergency services.

(c) **Determination of eligibility for programs offered through the Health Insurance Exchange.** ~~Effective October 1, 2013,~~ OHCA assesses applicants who are found to be ineligible for SoonerCare for potential eligibility for affordable insurance programs offered through the Health Insurance Exchange. OHCA does not determine eligibility or ineligibility for those programs. OHCA facilitates the determination for those affordable insurance programs by forwarding applicants' electronic applications to the Health Insurance Exchange.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 1. GENERAL

317:35-6-1. Scope and applicability

(a) The rules in this Subchapter apply when determining financial eligibility for SoonerCare ~~Health Benefits~~health benefits for groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:
(1) Children~~,~~;
(2) Pregnant women~~,~~;
(3) Pregnancy-related services under Title XXI~~,~~;
(4) Parents and caretaker relatives~~,~~;
(5) SoonerPlan ~~Family Planning~~family planning program~~,~~;
(6) Independent foster care adolescents~~,~~;
~~(7) Inpatients in public psychiatric facilities under 21, and~~
(7) Individuals under age twenty-one (21) in public psychiatric facilities;
(8) Tuberculosis~~.~~;
(9) Former foster care children;
(10) Children with non-IV-E adoption assistance;
(11) Individuals in adoptions subsidized in full or part by a public agency; and
(12) Expansion adults.

(b) See ~~42 Code of Federal Regulation, Sec. 435.603~~42 C.F.R. § 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.

(c) MAGI rules ~~take~~took effect on October 1, 2013.

PART 3. APPLICATION PROCEDURES

317:35-6-15. ~~Application for Pregnant Women and Families with Children~~SoonerCare application for pregnant women, families with children, and expansion adults; forms

(a) **Application.** An application for pregnant women ~~and~~ , families with children, and expansion adults consists of the SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. An individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare. ~~Effective October 1, 2013, individuals~~Individuals who wish to use a paper application form to apply for coverage under a MAGI eligibility group must submit the federal Single Streamlined Application to apply for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, ~~Health Department, in the county OKDHS office~~Oklahoma Department of Health, in the individual's county Oklahoma Department of Human Services (OKDHS) office, or online. A ~~face to face~~face-to-face interview is not required. Applications are mailed to the OHCA Eligibility Unit. When an individual indicates a need for SoonerCare, the physician or facility may forward an application to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application. ~~Effective October 1, 2013, an~~An application for SoonerCare may also be submitted through the Health Insurance Exchange.

(2) OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification of a need for medical services. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the SoonerCare ~~Application~~application form or OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If OKDHS form 08MA005E is received and a SoonerCare application cannot be completed, receipt of OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The applicant and provider are notified by computer-generated notice.

(5) A hospital providing services may file an electronic Notification of Date of Service (NODOS) form with OHCA up to five (5) days from the date services are rendered. The hospital, applicant, or someone acting on the applicant's behalf has fifteen (15) days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a ~~Notification of Date of Service~~NODOS does not guarantee coverage and if a completed application is not submitted within fifteen (15) days, the NODOS is void.

(b) **Date of application.** When an application is made online, the date of application is the date the application is submitted

online. The date of application for a paper application is the date a signed application is received and stamped in by contracted agency partners or OHCA. When a request for SoonerCare is made orally, and that request is followed within ~~20~~twenty (20) days by a signed application, the documented date of the oral request is the date of application. When OKDHS form 08MA005E is received by OKDHS, or received by OHCA and forwarded to OKDHS, the earliest of the date stamps is considered the date of request and should be honored when followed within ~~20~~twenty (20) days by a signed application for SoonerCare.

(c) **Other application and signature requirements.** For additional rules regarding other application and eligibility determination procedures, see Part 7 of Subchapter 5 of this Chapter.

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-36. Financial eligibility of individuals categorically related to ~~AFDC or pregnancy-related services~~aid to families with dependent children (AFDC), pregnancy-related services or expansion adults

(a) **~~Prior to October 1, 2013.~~** ~~In determining~~When determining financial eligibility for an individual related to AFDC ~~or~~, pregnancy-related services or expansion adults, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include the:

(1) ~~the individual~~Individual;

(2) ~~the spouse~~Spouse of the individual;

(3) ~~the biological~~Biological or adoptive parent(s) of the individual who is a minor dependent child. For ~~Health Benefits~~health benefits only, income of the stepparent of the minor dependent child is determined according to OAC 317:35-5-45;

(4) ~~minor~~Minor dependent children of the individual if the children are being included in the case for ~~Health Benefits~~health benefits. If the individual is ~~19~~nineteen (19) years or older and not pregnant, at least one (1) minor dependent child must be living in the home and included in the case for the individual to be related to AFDC;

(5) ~~blood~~Blood related siblings, of the individual who is a minor child, if they are included in the case for ~~Health Benefits;~~health benefits or;

(6) ~~a caretaker~~Caretaker relative and spouse (if any) and minor dependent children when the caretaker relative is to be included for coverage.

(b) **~~Prior to October 1, 2013.~~** ~~The family has the option to exclude~~

~~minor dependent children or blood related siblings [OAC 317:35-6-36(a)(4) and (5)] and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income must be included in the case. The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income.~~The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through 317:35-6-54.

~~(c) **Effective October 1, 2013.** The MAGI methodology is used to determine eligibility for MAGI eligibility groups. See OAC 317:35-6-39 through OAC 317:35-6-54.~~

~~(d)~~(c) **~~Effective October 1, 2013.~~** Individuals who are determined to be part of a MAGI household cannot be excluded from the household; likewise, income of individuals determined to be part of a MAGI household cannot be excluded unless the exclusion is expressly required under MAGI rules.

~~(e) When determining financial eligibility for an individual related to the children, parent or caretaker relative, or pregnancy groups, consideration is not given to income of any person who is aged, blind or disabled and receives SSI or is determined to be categorically needy.~~

317:35-6-37. Financial eligibility of categorically needy individuals related to ~~AFDC or pregnancy-related services~~aid to families with dependent children (AFDC), pregnancy-related services, parent/caretaker relatives, families with children, and expansion adults

Individuals whose income is less than the SoonerCare ~~Income Guidelines~~income guidelines for the applicable eligibility group are financially eligible for SoonerCare.

(1) **Categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on the SoonerCare ~~Income Guidelines~~income guidelines. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **Categorically related to ~~children's and parent/caretakers' groups~~ the children and parent/caretaker relative groups.**

(A) **Parent/~~caretakers'~~caretaker relative group.** For the individual in the parent/~~caretakers'~~caretaker relative group to be considered categorically needy, the SoonerCare ~~Income Guidelines~~income guidelines must be used.

(i) **~~SoonerCare Income Guidelines.~~** Individuals age ~~19~~nineteen (19) years or older, other than pregnant women, are determined categorically needy if countable income is ~~less~~equal to or less than the ~~Categorically~~

~~Needy Standard~~categorically needy standard, according to the family size.

(ii) **~~SoonerCare Income Guidelines.~~** ~~All~~ individuals under ~~19~~nineteen (19) years of age are determined categorically needy if countable income is equal to or less than the ~~Categorically Needy Standard~~categorically needy standard, according to the size of the family.

(B) **Families with children.** Individuals who meet financial eligibility criteria for the ~~children's~~children and parent/~~caretakers'~~caretaker relative groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to the ~~children's~~children or parent/~~caretakers'~~caretaker relative groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in ~~Work Supplementation~~work supplementation status who meet TANF eligibility conditions other than earned income.

(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the parent/caretaker relative.

(3) **Expansion adults.** Individuals who meet financial eligibility criteria for expansion adults are established and defined by 42 C.F.R. § 435.119 and by the Oklahoma Medicaid State Plan.

317:35-6-38. Hospital ~~Presumptive Eligibility~~presumptive eligibility (HPE)

(a) **General.** ~~Hospital Presumptive Eligibility (HPE)~~HPE is a limited period of SoonerCare eligibility for individuals who are categorically related to certain MAGI eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital ~~(see OAC 317:35-6-38(a)(2)(A) through (L)) for the conditions of a qualified hospital)~~ [see OAC 317:35-6-38(a)(2)(A) through (L) for the conditions of a qualified hospital], on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for SoonerCare services. The rules in this ~~section~~Section apply only to those individuals applying for, or qualified hospitals determining eligibility under, the HPE program.

(1) **Individuals eligible to participate in the HPE program.** To be eligible to participate in the HPE program, an individual

must be categorically related to a MAGI eligibility group (see OAC 317:35-5-2 for categorical relationship criteria) and also meet the income standard and non-medical eligibility specified in this ~~section~~Section.

(A) **MAGI ~~Eligibility Groups~~eligibility groups**. The following MAGI eligibility groups are eligible to have a presumptive eligibility (PE) determination made by a qualified hospital participating in the HPE program:

(i) ~~children~~Children;

(ii) ~~pregnant~~Pregnant women;

(iii) ~~parents and caretaker relatives~~Parent/caretaker relative;

(iv) ~~former~~Former foster care children;

(v) Breast and Cervical Cancer ~~Treatment~~ (BCC) treatment program; and

(vi) SoonerPlan ~~Family planning~~family planning program.

(B) **Income standard.** The income that is counted in determining PE for an individual is that individual's household income. The income limit for the MAGI eligibility groups covered under the HPE program is the same as defined in OAC 317:35-6-39(b)(8) and is listed on the HPE application. The calculation of countable household income for an individual covered under the HPE program is the same as OAC 317:35-6-39, except that, in determining the individual's household composition, only the MAGI household composition non-filer rules listed under OAC 317:35-6-43 apply for all individuals applying for the HPE program regardless of whether or not the individual is a tax filer, plans on filing taxes, or is a tax dependent.

(C) **Non-medical eligibility requirements.** Individuals covered under the HPE program must also meet the non-medical eligibility requirements described in OAC 317:35-5-25.

(D) **Pregnant women covered under the HPE program.** Coverage for pregnant women who are covered under the HPE program is limited to ambulatory prenatal care only, and the number of PE periods that may be authorized for pregnant women is one per pregnancy. Pregnant women who may be covered for the benefit of the unborn child(ren) under Title XXI are not eligible for the HPE program.

(E) **Other individuals covered under the HPE program.** Coverage for other individuals listed under OAC 317:35-6-38(a)(1)(A)(i) through (vi) who are covered under the HPE program, except for pregnant women, is the same as covered under the State Plan. The number of PE periods that may be authorized is one period every ~~365~~three hundred sixty-five (365) days beginning on the date the individual is enrolled in HPE.

(2) **Qualified hospital.** The decision that a hospital is qualified to make PE determinations is made by the OHCA. In order to participate in the HPE program and make PE determinations, a qualified hospital must:

(A) Meet all the conditions of an eligible provider under OAC 317:30-5-40;

(B) Elect to participate in the HPE program by:

(i) Completing and submitting a HPE Statement of Intent and Memorandum of Understanding to the OHCA and agreeing to all the terms and conditions of the HPE program;

(ii) Amending its current contract with the OHCA to include participation in the HPE program;

(C) Assign and designate a hospital employee to serve as the HPE program administrator and point of contact;

(D) Assign and designate hospital employees to make PE determinations. The term ~~Authorized Hospital Employee(s) (AHE)~~"authorized hospital employee(s) (AHE)" means all individuals making PE determinations on behalf of a hospital participating in the HPE program. The AHE must meet the following conditions:

(i) Be an employee of the hospital (i.e. the AHE may not be a third party contractor);

(ii) Attend, complete, and pass the HPE program training course provided and assessed by the OHCA;

(iii) The AHE certificate of HPE course completion must be kept in the worker's file at the hospital and must be made available to the OHCA upon request;

(iv) Follow state and federal privacy and security requirements regarding patient confidentiality;

(v) Agree to abide by all the rules and guidelines of the HPE program established by the OHCA under this ~~section~~Section.

(E) Notify the OHCA of any changes in the AHE's employment status or in the designation of that individual as the hospital's AHE;

(F) Abide by the rules and regulations of the Uniform Electronic Transaction Act as outlined in OAC 317:30-3-4.1;

(G) Keep internal records of all individuals for whom a PE determination was made and make those records available to the OHCA upon request;

(H) Agree to submit all completed HPE applications and PE determinations to the OHCA within ~~5~~five (5) days of the PE determination;

(I) Notify the applicant in writing, or in cases where the HPE application was made on behalf of a child, notify the child's parent or caretaker of the PE determination outcome and provide and explain to eligible members the "HPE Program

Policy and Enrollment" form;

(J) Assist HPE applicants with the completion of a full SoonerCare application within ~~15~~fifteen (15) days of the HPE application submission to the OHCA;

(K) Agree to adhere to the processes and procedures established by the OHCA regarding the operation and oversight of the HPE program; and

(L) Cooperate with the OHCA regarding audit and quality control reviews on PE determinations the hospital makes. The agency may terminate the HPE agreement with the hospital if the hospital does not meet the standards and quality requirements set by the OHCA.

(3) **Limited hospital PE determinations.** The agency limits the PE determinations that a hospital may make to only those eligibility groups described in OAC 317:35-6-38(a)(1)(A) using the MAGI methodology rules established for the HPE program. Additionally, PE determinations made for individuals categorically related to the Breast and Cervical Cancer ~~Treatment~~(BCC) treatment program are limited to qualified hospitals that are also qualified entities through the ~~NBCCEDP~~National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

(b) **General provisions of the HPE program.** The agency provides SoonerCare coverage to eligible individuals covered during a period of PE.

(1) **PE period.** The PE period begins on the date a qualified hospital determines an individual to be eligible under the HPE program. A qualified hospital has ~~5~~five (5) days to notify the agency of its PE determination. The PE period ends with the earlier of:

(A) The day the agency receives the SoonerCare application form as described in OAC 317:35-5-60 and an eligibility determination is made by the agency; or

(B) If a SoonerCare application is not received, the last day of the month following the month in which the PE determination was made.

(2) **Agency approval of PE.** When the OHCA receives a timely and completed HPE application, a case number and, if needed, SoonerCare member ID is assigned to the member by the agency. Qualified hospitals will be able to review member enrollment and eligibility, once those members have been entered into the system by the OHCA, for claims billing and member eligibility verification.

(3) **Incomplete HPE applications.** Upon receiving a HPE ~~Application~~application, the OHCA reviews it for completeness and correctness. The HPE application is considered incomplete if it is not filled out in its entirety (e.g., the applicant's

first or last name is not provided on the application) or if the application is not filed timely with the OHCA. When the HPE application is determined to be incomplete, the HPE application is returned to the AHE or the HPE program administrator at the qualified hospital to correct the application errors or amend the HPE application. To maintain the original PE certification period, the qualified hospital must return the completed or corrected HPE application to the agency within five (5) working days.

(4) **Applicant appeal.** The HPE applicant cannot appeal the PE determination made by a qualified hospital or the expiration date of the PE period.

(5) **Applicant ineligibility.** Applicants ineligible for the HPE program are individuals who do not meet the HPE criteria, individuals who have previously been enrolled in the HPE program within the last ~~365~~three hundred sixty-five (365) days, and individuals currently enrolled in SoonerCare. Individuals currently enrolled in SoonerPlan ~~Family Planning~~family planning are not eligible for HPE family planning services, but may be eligible for other programs under HPE. When the OHCA receives a HPE application from a qualified hospital for an ineligible applicant ~~(e.g., the applicant has been previously enrolled in the HPE program within the last 365 days)~~[e.g., the applicant has been previously enrolled in the HPE program within the last three hundred sixty-five (365) days], the OHCA will disenroll the individual from the HPE program immediately and notify the hospital of the error. The hospital will be responsible for following up with that individual to notify them of their disenrollment from the HPE program. If the applicant is not currently enrolled into SoonerCare, the applicant may submit a full SoonerCare application and receive a full eligibility determination by the OHCA. HPE services provided to ineligible applicants, other than persons currently enrolled into SoonerCare or SoonerPlan ~~Family Planning~~family planning program, may not be eligible for reimbursement by the OHCA.

SUBCHAPTER 7. MEDICAL SERVICES

PART 1. GENERAL

317:35-7-1. Scope and applicability

~~The rules in this Subchapter apply when determining eligibility for Medical Services under Medicaid.~~ The rules in this Subchapter apply when determining eligibility for medical services for children who are reported by OKDHS as being in custody and individuals categorically related to: Aged, Blind and Disabled (ABD); Tuberculosis; SoonerPlan family planning program; Qualified

Medicare Beneficiary Plus (QMBP); Qualified Disabled Working Individual (QDWI); Specified Low-Income Medicare Beneficiary (SLMB); Qualifying Individual (QI-1); and TEFRA.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60. Certification for SoonerCare

~~(a) The rules in this Section apply to all categories of eligibles~~ ~~**EXCEPT:**~~

~~(1) categorically needy SoonerCare members who are categorically related to AFDC or Pregnancy Related Services, AND~~

~~(2) who if eligible, would be enrolled in SoonerCare, or~~

~~(3) individuals categorically related to the Family Planning Program.~~

~~(b) An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the first day of the third month prior to the month of application if all eligibility criteria are met during the three month period. The certification period is determined beginning with the month the medical service was received or expected to be received or the month of application for categorically needy cases in which a medical service has not been received. The period of certification may cover retroactive or future months.~~

~~(1) **Certification as categorically**. A categorically needy individual who is categorically related to ABD is assigned a certification period of 12 months. A categorically needy individual who is determined eligible for a State Supplemental Payment (SSP) is certified effective the month of application. If the individual is also eligible for payment for medical services received during the three months preceding the month of application, the SoonerCare benefit is certified for the appropriate months. If the individual is not eligible for SSP, the first month of certification is the month that a medical service was provided or, if no medical service was provided, the month of application.~~

~~(1) **Certification of individuals categorically needy and categorically related to ABD.** The certification period for the individual categorically related to ABD can be assigned for up to 12 months. The individual must be determined as categorically needy for each month of the certification period. The certification period is 12 months unless the individual:~~

~~(i) is certified as eligible in a money payment case during the 12 month period;~~

~~(ii) is certified for long-term care during the 12 month period;~~

~~(iii) becomes ineligible for medical assistance after the~~

~~initial month;~~
~~(iv) becomes ineligible as categorically needy; or~~
~~(v) is deceased.~~
~~(B) **Certification period.** If any of the situations listed in subparagraph (A) of this paragraph occur after the initial month, the case is closed by the worker.~~
~~(i) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.~~
~~(ii) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.~~

(a) **General.** The rules in this Section apply to the following categories of eligibles:

(1) Categorically needy SoonerCare members who are categorically related to Aged, Blind, and Disabled (ABD);

(2) Categorically needy SoonerCare members who are categorically related to ABD, and are eligible for one of the following:

(A) Qualified Medicare Beneficiary Plus (QMBP);

(B) Qualified Disabled and Working Individual (QDWI);

(C) Specified Low-Income Medicare Beneficiary (SLMB);

(D) Tuberculosis (TB) related services;

(E) Qualifying Individual (QI); or

(F) Tax Equity and Fiscal Responsibility Act (TEFRA).

(b) **Certification of individuals categorically needy and categorically related to ABD.** The certification period for the categorically needy individual who is categorically related to ABD can be up to twelve (12) months from the date of certification. The individual must meet all factors of eligibility for each month of the certification period. The certification can be for a retroactive period of coverage, during the three (3) months directly before the month of application, if the individual received covered medical services at any time during those three (3) months and would have been eligible for SoonerCare at the time he or she received the services. The cash payment portion of the State Supplemental Payment (SSP) may not be paid for any period prior to the month of application.

(1) The certification period is twelve (12) months unless the individual:

(A) Is certified as eligible in a money payment case during the twelve (12) month period;

(B) Is certified for long-term care during the twelve (12) month period;

(C) Becomes ineligible for medical assistance after the initial month;

(D) Becomes ineligible as categorically needy; or

(E) Is deceased.

(2) If any of the situations listed in subparagraph (1) of this paragraph occur after the initial month, the case is closed by the worker.

(A) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.

(B) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

~~(2)~~(c) **Certification of individuals categorically related to ABD and eligible as ~~Qualified Medicare Beneficiaries Plus~~QMBP**. The SoonerCare benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

~~(A)~~(1) An individual determined eligible for QMBP benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

~~(B)~~(2) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

~~(3)~~(d) **Certification of individuals categorically related to ABD and eligible as ~~Qualified Disabled and Working Individual~~QDWI**. The Social Security Administration (SSA) is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State ~~Office~~office receives referrals from the SSA, the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that he/she is a potential QDWI, the county takes a SoonerCare application. The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 ~~(~~[or up to three (3) months prior to October 1, if all eligibility criteria

are met during the three (3) month period~~)~~]. However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of ~~12~~twelve (12) months. At the end of the ~~12-month~~twelve (12) month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed.

~~(4)~~(e) **Certification of individuals categorically related to ABD and eligible as ~~Specified Low-Income Medicare Beneficiary (SLMB)~~SLMB.** The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other SoonerCare benefits such as long-term care.

~~(5)~~(f) **Certification of individuals categorically related to disability and eligible for TB related services.**

~~(A)~~(1) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, but no earlier than the first day of the month the TB infection is diagnosed.

~~(B)~~(2) A certification period of ~~12~~twelve (12) months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

~~(C)~~(3) At the end of the certification period a new application will be required if additional treatment is needed.

~~(6)~~(g) **Certification of individuals categorically related to ABD and eligible as ~~Qualifying Individuals~~QI.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of ~~12~~twelve (12) months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

~~(A)~~(1) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.
~~(B)~~(2) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.

~~(7)~~(h) **Certification of individuals ~~Related~~related to Aid to the Disabled for TEFRA.** The certification period for individuals categorically related to the Disabled for TEFRA is ~~12~~twelve (12) months.

SUBCHAPTER 10. OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 3. RESOURCES

317:35-10-10. Capital resources

Capital resources are disregarded for individuals related to the children, parent and caretaker relative, former foster care children, SoonerPlan family planning program, expansion adults, or pregnancy eligibility groups, including pregnancies covered under Title XXI. Countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

PART 5. INCOME

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to the children, ~~parent or caretaker relative~~parent/caretaker relative, SoonerPlan family planning program, ~~or~~ Title XIX and XXI pregnancy eligibility groups or expansion adults does not require verification, unless questionable. If the income information is questionable, it must be verified. If there appears to be a conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or ~~OHCA's~~Oklahoma Health Care Authority's (OHCA's) policy, is taken into consideration in determining need. Income is considered available both when it is actually available and

when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the ~~Oklahoma Health Care Authority (OHCA)~~OHCA. The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within ten (10) days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to ~~a~~an SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. The ~~MAGI~~Modified Adjusted Gross Income (MAGI) methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-6-1.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. If OHCA is unable to verify income through the Oklahoma Employment Securities Commission, then pay stubs may only be used for verification if they have

the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer and provided to OHCA within ten (10) days. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received, with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age eighteen (18) are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Whether a source of income is countable for MAGI eligibility groups is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(B) Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy. Income received by a stepparent is considered in accordance with MAGI household and income counting rules.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one (1) month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six (6) months,

will be averaged and considered as income for the next six (6) months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six (6) months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company. Whether a source of income is countable is determined in accordance with Part 6 of Subchapter 6 of this Chapter.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two (2) months to establish the amount to be anticipated and considered for prospective budgeting.

(6) MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) MAGI household and income counting rules are used to determine whether a caretaker relative and his/her spouse or a stepparent are included in the household and whether their income is considered for the children.

(B) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted. If an individual is eligible in the parent or caretaker relative group, his/her spouse, if living with him/her, is also related to the parent or caretaker relative group.

(7) A stepparent, if living with the parent or caretaker relative, can also be related to the parent or caretaker relative group, regardless of whether the parent is incapacitated or not in the home.

(8) MAGI household and income counting rules are used to determine whose income is considered and whether that income is counted.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Whether income is countable for MAGI eligibility groups is determined using MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(1) **Earned income from self-employment.** For MAGI eligibility groups, the calculation of countable self-employment income is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(2) **Earned income from wages, salary or commission.** Countable income for MAGI eligibility groups is determined in accordance

with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(3) **Earned income from work and training programs.** Countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(4) **No individual earned income exemptions.** No earned income exemptions are subtracted to determine countable income for MAGI eligibility groups. The only deduction applied to determine net countable income under the MAGI methodology is the deduction of five percent (5%) of the ~~FPL~~Federal Poverty Level (FPL) for the individual's household size as defined in OAC 317:35-6-39.

(5) **Formula for determining the individual's net earned income for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income.** Countable earned and unearned income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

(d) **Income disregards.** For MAGI eligibility groups, whether a source of income is disregarded is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.

~~(g)~~(e) **Computing monthly income.** In computing monthly income, cents will be rounded down at each step. Income which is received monthly but in irregular amounts is averaged using two (2) month's income, if possible, to determine income eligibility. Less than two (2) month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(1) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(2) **Weekly.** Income received weekly is multiplied by 4.3.

(3) **Twice a month.** Income received twice a month is multiplied by two (2).

(4) **Biweekly.** Income received every two (2) weeks is multiplied by 2.15.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma program that establishes access to affordable health coverage for low-income working adults~~,~~ their dependents, and their spouses; foster parents; and qualified college students.

317:45-1-2. Program limitations

(a) The Insure Oklahoma program is contingent upon federal waiver approval and sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the ~~OHCA~~Oklahoma Health Care Authority (OHCA) to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, ~~Okla. Stat. '68-302-5~~Title 68 of the Oklahoma Statutes (O.S.) § 302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to ~~Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes~~68 O.S. §§ 302-5 (B)(1) & (C)(1) and 402-3 (B)(1) & (D)(1).

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma program continues to operate within its fiscal capacity.

(A) Insure Oklahoma may limit eligibility based on:

(i) ~~the federally-approved Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver~~The 1115 Waiver;

(ii) Tobacco ~~Tax~~tax collections; and

(iii) ~~the~~The State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma program ~~are~~may be placed on a waiting list. Applications, with the exception of college students, are identified by region ~~and Insure Oklahoma program~~. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate.

(vi) For approved employers, if the employer has an employee who has a qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the qualifying event.

(b) College student eligibility and participation in the Insure Oklahoma program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) ~~an~~An insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both

and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) ~~a~~A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) ~~a~~A domestic MEWA exempt from licensing pursuant to Title 36 ~~O.S., Section~~of the Oklahoma Statutes (O.S.) § 634(B) that otherwise meets or exceeds all ~~of~~ the licensing and financial requirements of MEWAs as set out in ~~Article 6A of Title 36~~Title 36 O.S.; or

(D) ~~any~~Any entity organized pursuant to the Interlocal Cooperation Act, ~~Section 1001 et seq. of Title 74 of the Oklahoma Statutes~~74 O.S. § 1001 et seq. as authorized by ~~Title 36 Section 607.1 of the Oklahoma Statutes~~36 O.S. § 607.1 and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child ~~Care Center~~care center" means a facility licensed by the Oklahoma Department of Human Services (DHS) which provides care and supervision of children and meets all the requirements in OAC ~~340:110-3-1 through OAC 340:110-3-33.3~~340:110-3-275 through 340:110-3-311.

"College ~~Student~~student" means an Oklahoma resident between the age of nineteen (19) through twenty-two (22) that is a full-time student at an Oklahoma accredited ~~University~~university or ~~College~~college.

~~**"DHS"** means the Oklahoma Department of Human Services.~~

"Dependent" means the spouse of the approved applicant and/or child under nineteen (19) years of age or his or her child nineteen (19) years through twenty-two (22) years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance (ESI)" means the program that provides premium assistance to qualified businesses for approved applicants.

"Explanation of Benefit (EOB)" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma member.

"Full-time ~~Employer~~employer" means the employer who employs an employee per Federal and State regulations, to perform work in exchange for wages or salary.

"Full-time ~~Employment~~employment" means a normal work week per Federal and State regulations.

~~**"Individual Plan (IP)"** means the safety net program for those qualified individuals who do not have access to Insure Oklahoma ESI.~~

"In-network" means providers or health care facilities that are part of a benefit plan's network of providers with which it has negotiated a discount, and services provided by a physician or other health care provider with a contractual agreement with the insurance company paid at the highest benefit level.

"Insure Oklahoma (IO)" means a benefit plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of benefit plan coverage for eligible populations.

"Member" means an individual enrolled in the Insure Oklahoma ESI ~~or IP~~ program.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

"OAC" means the Oklahoma Administrative Code.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"Premium" means a monthly payment to a carrier for benefit plan coverage.

"Primary ~~Care Provider~~care provider (PCP)" means a provider under contract with the OHCA to provide primary care services, including all medically necessary referrals.

"Professional ~~Employer Organization~~employer organization (PEO)" means any person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in ~~Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et. seq~~40 O.S. § 600.1 et. seq.

"Qualified ~~Benefit Plan~~benefit plan (QBP)" means a benefit plan that has been approved by the OHCA for participation in the Insure Oklahoma program.

"Qualifying ~~Event~~event" means the occurrence of an event that permits individuals to join a group benefit plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's benefit plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the OHCA.

317:45-1-4. Reimbursement for out-of-pocket expenses

(a) Out-of-pocket expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to five (5) percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket expenses in excess of the five (5) percent annual gross household income. An expense must be for an allowed and covered service by a ~~qualified benefit plan (QBP)~~QBP to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a QBP's benefit summary and policies. For instance, if a QBP has multiple in-network reimbursement percentage methodologies (~~80%~~eighty (80) percent for level 1 provider and ~~70%~~seventy (70) percent for level 2 provider) the OHCA will only reimburse expenses related to the highest percentage network.

(b) For all eligible expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket expense. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket expenses.

SUBCHAPTER 7. INSURE OKLAHOMA ESI EMPLOYER ELIGIBILITY

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current benefit plan invoice. Due to timely filing requirements, subsidy payments will not be paid on invoices older than six (6) months.

SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination will be processed within thirty (30) days from the date the application is received. The employee will be notified in writing of the eligibility decision.

(c) All eligible employees described in this section must be enrolled in their employer's qualified benefit plan. Eligible employees must:

(1) ~~have~~Have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma ESI Income Guidelines form;

(A) ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma ESI Benefits.

(2) ~~be~~Be a US citizen or alien as described in OAC 317:35-5-25;

(3) ~~be~~Be Oklahoma residents;

(4) ~~furnish~~Furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma ESI benefits;

(5) ~~not~~Not be receiving benefits from SoonerCare or Medicare;

(6) ~~be~~Be employed with a qualified employer at a business location in Oklahoma;

(7) ~~be~~Be age nineteen (19) through age sixty-four (64);

(8) ~~be~~Be eligible for enrollment in the employer's ~~qualified benefit plan~~QBP;

(9) ~~not~~Not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2);

(10) ~~select~~Select one of the ~~qualified benefit plans~~QBPs the employer is offering; and

(11) ~~provide~~Provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) An employee's dependents are eligible when:

(1) ~~the~~The employer's benefit plan includes coverage for dependents;

(2) ~~the~~The employee is eligible;

(3) ~~if~~If employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1 (a) (1)-(2); and

(4) ~~the~~The dependents are enrolled in the same benefit plan as the employee.

(e) If an employee or their dependents are eligible for multiple ~~qualified benefit plans~~QBPs, each may receive a subsidy under only one benefit plan.

(f) College students may enroll in the Insure Oklahoma ESI program as dependents. ~~Effective January 1, 2016, financial~~Financial

eligibility for Insure Oklahoma ESI benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.

(g) Working dependent children must have countable income at the appropriate standard according to the family size on the Insure Oklahoma ESI Income Limits Guidelines form. ~~Effective January 1, 2016, financial~~Financial eligibility for Insure Oklahoma ESI benefits is determined using the MAGI methodology. See OAC 317:35-6-39 through ~~OAC 317:35-6-54~~317:35-6-55 for the applicable MAGI rules for determining household composition and countable income. Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(h) ESI approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within ten (10) days of the change.

(i) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

SUBCHAPTER 11. INSURE OKLAHOMA IP [REVOKED]

PART 1. INDIVIDUAL PLAN PROVIDERS [REVOKED]

317:45-11-1. Insure Oklahoma Individual Plan providers [REVOKED]

~~Insure Oklahoma Individual Plan (IP) providers must comply with existing SoonerCare rules found at 317:25 and 317:30. In order to receive reimbursement, the IP provider:~~

~~(1) must enter into a SoonerCare contract; and~~

~~(2) must complete Insure Oklahoma IP addendum if provider wants to provide primary care services as a PCP.~~

317:45-11-2. Insure Oklahoma Individual Plan (IP) provider payments [REVOKED]

~~Payment for covered benefits rendered to Insure Oklahoma IP members is made to contracted Insure Oklahoma IP healthcare~~

~~providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in Oklahoma Administrative Code 317:30-3-1(f).~~

~~(1) Coverage of certain services requires prior authorization and may be based on a determination made by a medical consultant in individual circumstances; and~~

~~(2) The provider may collect the member's co-payment in addition to the SoonerCare reimbursement for services provided.~~

PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS [REVOKED]

317:45-11-10. Insure Oklahoma IP adult benefit [REVOKED]

~~(a) All IP adult benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in OAC 317:45-11-11.~~

~~(b) A PCP referral is required to see any other provider with the exception of the following services:~~

~~(1) behavioral health services;~~

~~(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;~~

~~(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;~~

~~(4) women's routine and preventive health care services;~~

~~(5) emergency medical condition as defined in OAC 317:30-3-1; and~~

~~(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.~~

~~(c) IP covered adult benefits for in-network services and limits are listed in this subsection. Member cost sharing related to premium and co-payments cannot exceed federal maximums with the exception of emergency room visits, in which case the State establishes the maximum for member cost share. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage for IP services includes:~~

~~(1) Anesthesia/Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).~~

~~(2) Blood and Blood Products. Processing, storage, and~~

~~administration of blood and blood products in inpatient and outpatient settings.~~

~~(3) Chelation Therapy. Covered for heavy metal poisoning only.~~

~~(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required.~~

~~(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.~~

~~(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, OAC 317:30-5-47 and OAC 317:30-5-95.~~

~~(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year. This visit counts as an office visit.~~

~~(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, OAC 317:30-5-10, and OAC 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits.~~

~~(9) Outpatient Hospital/Facility Services.~~

~~(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures.~~

~~(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections.~~

~~(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Must be hospital-based.~~

~~(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22.~~

~~(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20.~~

~~(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901.~~

~~(13) Immunizations. Covered in accordance with OAC 317:30-5-2.~~

~~(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.~~

~~(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility.~~

~~(16) Oral Surgery. Services are limited to the removal of tumors or cysts.~~

~~(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1.~~

~~(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.~~

~~(A) Agency services. Covered in accordance with OAC 317:30-5-241 and OAC 317:30-5-596.~~

~~(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:~~

~~(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.~~

~~(ii) Practitioners with a license to practice in the state in which services are provided.~~

~~(I) Psychology,~~
~~(II) Social Work (clinical specialty only),~~
~~(III) Professional Counselor,~~
~~(IV) Marriage and Family Therapist,~~
~~(V) Behavioral Practitioner, or~~
~~(VI) Alcohol and Drug Counselor.~~

~~(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.~~

~~(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.~~

~~(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.~~

~~(vi) LBHP services require prior authorization and are limited to four (4) therapy services per month per member and eight (8) testing units per year per member.~~

~~(19) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5-210 through OAC 317:30-5-218. A PCP referral and prior authorization is required for certain items.~~

~~(20) Diabetic Supplies. Covered in accordance with OAC 317:30-~~

~~5-211.15.~~

~~(21) Oxygen. Covered in accordance with OAC 317:30-5-211.11 through OAC 317:30-5-211.12.~~

~~(22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and OAC 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits.~~

~~(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1.~~

~~(24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076.~~

~~(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13.~~

~~(26) Surgery. Covered in accordance with OAC 317:30-5-8.~~

~~(27) Home Dialysis. Covered in accordance with OAC 317:30-5-211.13.~~

~~(28) Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14.~~

~~(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57.~~

~~(30) Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and OAC 317:30-5-42.16(b)(3).~~

~~(31) Fundus photography.~~

~~(32) Emergency ground ambulance transportation. Covered in accordance with OAC 317:30-5-336.~~

317:45-11-11. Insure Oklahoma IP adult non-covered services [REVOKED]

~~Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:~~

~~(1) services not considered medically necessary;~~

~~(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;~~

~~(3) organ and tissue transplant services;~~

~~(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;~~

~~(5) procedures, services and supplies related to sex transformation;~~

~~(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;~~

~~(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);~~
~~(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;~~
~~(9) experimental procedures, drugs or treatments;~~
~~(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident);~~
~~(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;~~
~~(12) physical medicine including chiropractic and acupuncture therapy;~~
~~(13) hearing services;~~
~~(14) non-emergency transportation and emergency air transportation;~~
~~(15) allergy testing and treatment;~~
~~(16) hospice regardless of location;~~
~~(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);~~
~~(18) genetic counseling;~~
~~(19) fertility evaluation/treatment/and services;~~
~~(20) sterilization reversal;~~
~~(21) Christian Science Nurse;~~
~~(22) Christian Science Practitioner;~~
~~(23) skilled nursing facility;~~
~~(24) long-term care;~~
~~(25) stand by services;~~
~~(26) thermograms;~~
~~(27) abortions (for exceptions, refer to OAC 317:30-5-6);~~
~~(28) services of a Lactation Consultant;~~
~~(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;~~
~~(30) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1;~~
~~(31) ultraviolet treatment-actinotherapy;~~
~~(32) private duty nursing;~~
~~(33) payment for removal of benign skin lesions;~~
~~(34) sleep studies;~~
~~(35) prosthetic devices; and~~
~~(36) continuous positive airway pressure devices (CPAP).~~

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY [REVOKED]

317:45-11-20. Insure Oklahoma IP eligibility requirements [REVOKED]

~~(a) Oklahoma employed working adults not eligible to participate in an employer's qualified benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply~~

~~for the Individual Plan. Applicants, unless a qualified college student, must be: considered "employed" in accordance with State law, including, but not limited to, Title 40 O.S. ' 1-210; engaged in routine, for-profit activity, if self-employed; or considered "unemployed" in accordance with State law, including, but not limited to Title 40 O.S. ' 1-217. Applicants cannot obtain IP coverage if they are eligible for ESI.~~

~~(b) The eligibility determination will be processed within thirty (30) days from the date the complete application is received. The applicant will be notified of the eligibility decision.~~

~~(c) In order to be eligible for the IP, the applicant must:~~

~~(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time he/she completes application;~~

~~(2) be a US citizen or alien as described in OAC 317:35-5-25;~~

~~(3) be an Oklahoma resident;~~

~~(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP benefits;~~

~~(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;~~

~~(6) be age 19 through 64;~~

~~(7) make premium payments by the due date on the invoice;~~

~~(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a) (1)-(2);~~

~~(9) be not currently covered by a private insurance policy or plan; and~~

~~(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.~~

~~(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and:~~

~~(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits;~~

~~(2) be ineligible for participation in their employer's qualified benefit plan due to number of hours worked.~~

~~(c) If employed and working for an employer who does not offer a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.~~

~~(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:~~

~~(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.~~

~~(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.~~

~~(2) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).~~

~~(3) must verify self-employment by completing and submitting to Insure Oklahoma the Self-Employment Attestation Form. In addition,~~

~~(A) for any applicant who filed a Federal tax return for the tax year immediately preceding the date of application, he or she must provide a copy of such tax return with all supporting schedules and forms, or~~

~~(B) for any applicant exempt from filing a Federal tax return for the previous tax year in accordance with Federal law, including, but not limited to, 26 Code of Federal Regulation, Section 1.6017-1, he or she must submit a completed 12-Month Profit and Loss Worksheet to Insure Oklahoma, as well as any other information requested by Insure Oklahoma that could reasonably be used to substantiate the applicant's regular, for-profit business activity.~~

~~(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:~~

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits. Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) A OESC eligibility letter;

(B) A OESC weekly unemployment payment statement, or;

(C) A bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work program.

(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.

(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

(k) College students may enroll in the Insure Oklahoma IP program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income

~~(including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA) or the university's financial aid office. College students must also provide a copy of their current student schedule to prove full-time student status.~~

~~(l) Any misleading or false representation, or omission of any material fact or information required or requested by OHCA as part of the Insure Oklahoma application process, may result in, among other things, closure of eligibility pursuant to OAC 317:45-11-27.~~

317:45-11-21. Dependent eligibility [REVOKED]

~~(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage if they are eligible for Insure Oklahoma ESI.~~

~~(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.~~

~~(c) The dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.~~

~~(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated dependent enrolled under that applicant is also ineligible.~~

~~(e) College students may enroll in the Insure Oklahoma IP program. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students' are determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.~~

~~(f) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.~~

~~(g) When the agency responsible for determining eligibility for the member becomes aware of a change in the dependents circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.~~

317:45-11-21.1. Certification of newborn child deemed eligible [REVOKED]

~~(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma Individual Plan (IP) and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible for SoonerCare benefits through the last day of the month the child attains the age of one (1) year.~~
~~(b) The newborn child's SoonerCare eligibility is not dependent on the mother's continued eligibility in Insure Oklahoma IP. The child's SoonerCare eligibility is based on the original eligibility determination of the mother for Insure Oklahoma IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.~~
~~(c) The newborn child's certification period for SoonerCare is shortened only in the event the child:~~
~~(1) Loses Oklahoma residence; or~~
~~(2) Expires.~~
~~(d) No other conditions of eligibility are applicable, including social security number enumeration and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.~~

317:45-11-22. Primary Care Physician (PCP) choices [REVOKED]

~~(a) The applicant and any covered dependent(s) are required to select a valid PCP.~~
~~(b) The applicant and any covered dependent(s) must make a PCP selection though their mysoonercare.org account.~~
~~(c) After initial enrollment in Insure Oklahoma Individual Plan the applicant any covered dependent(s) may change their PCP selection through their mysoonercare.org account or by calling the Insure Oklahoma helpline.~~
~~(d) To ensure members have access to their Patient Centered Medical Home, Insure Oklahoma staff may facilitate enrollment as applicable.~~

317:45-11-23. Member eligibility period [REVOKED]

~~(a) The rules in this subsection apply to member's eligibility according to OAC 317:45-11-20(a) through (e).~~
~~(1) The member's eligibility period begins only after approval of the application and receipt of the premium payment.~~
~~(A) If the application is approved and the premium payment is made by the last day of the same month, eligibility will begin the first day of the next month.~~
~~(B) If the application is approved and the premium payment is made between the first and 15th day of the next month, eligibility will begin the first day of the second consecutive month.~~

(C) If the application is approved and the premium payment is not made within 45 days, eligibility will not begin.

(2) Employee eligibility is contingent upon the employer meeting the program guidelines.

(3) The employee's eligibility is determined using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20 (a) through (e).

(4) If the employee is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than 12 months.

(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(1) The applicant's eligibility is determined using the eligibility requirements listed in OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(2) If the applicant is determined eligible for Insure Oklahoma IP, he/she is approved for a period not greater than twelve (12) months.

(3) The applicant's eligibility period begins only after receipt of the premium payment.

317:45-11-24. Member cost sharing [REVOKED]

(a) Members are given monthly invoices for their benefit plan premiums. IP health plan premiums are established by the OHCA. The premiums are due monthly and must be paid in full.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent (4%) of their monthly gross household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent (4%) of their monthly gross household income, based on a family size of one and capped at one-hundred percent (100%) of the Federal Poverty Level.

(3) Cost-sharing, including premium payments and copayments, are not required of American Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of returned payments.

317:45-11-26. Reviews [REVOKED]

Members participating in the Insure Oklahoma program are subject to reviews related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies

~~paid in error will be subject to recoupment.~~

317:45-11-27. Closure [REVOKED]

~~(a) Members are mailed a notice 10 days prior to closure of eligibility.~~

~~(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma then eligibility for the associated employees enrolled under that employer are also ineligible.~~

~~(c) The employee's certification period may be terminated when:~~

~~(1) the member requests closure;~~

~~(2) the member moves out-of-state;~~

~~(3) the covered member dies;~~

~~(4) the employer's eligibility ends;~~

~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~

~~(6) the employer is terminated from Insure Oklahoma;~~

~~(7) the member fails to pay their premium;~~

~~(8) the qualified benefit plan or carrier no longer meets the requirements set forth in this chapter;~~

~~(9) the member begins receiving SoonerCare or Medicare benefits;~~

~~(10) the member begins receiving coverage by a private benefit policy or plan;~~

~~(11) the member or employer reports any change affecting eligibility; or~~

~~(12) the member no longer meets the eligibility criteria set forth in this Chapter.~~

~~(d) This subsection applies to applicants eligible according to 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:~~

~~(1) the member requests closure;~~

~~(2) the member moves out-of-state;~~

~~(3) the covered member dies;~~

~~(4) the employer's eligibility ends;~~

~~(5) a review indicates a discrepancy that makes the member or employer ineligible;~~

~~(6) the member fails to pay their premium;~~

~~(7) the member becomes eligible for SoonerCare or Medicare;~~

~~(8) the member begins receiving coverage by a private benefit policy or plan;~~

~~(9) the member or employer reports any change affecting eligibility; or~~

~~(10) the member no longer meets the eligibility criteria set forth in this Chapter.~~

317:45-11-28. Appeals [REVOKED]

~~Member appeal procedures based on denial of eligibility due to income are described at 317:2-1-2.~~

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, or the Bureau of Indian Affairs ~~(BIA)~~.

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the Oklahoma Department of Human Services (OKDHS) State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms.** The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the

provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A MQT is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a

claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 Oklahoma Statutes 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device**. MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment**. For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for

his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

(ii) the individual's spouse;

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

(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the

individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the ~~60~~sixty (60) months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the ~~60~~sixty (60) months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of ~~65~~sixty-five (65) which was established for the benefit of such individual by the individual, parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(i) The trust may only contain the assets of the disabled individual.

(ii) The trust must be irrevocable and cannot be amended

or dissolved without the written agreement of the OKDHS or the Oklahoma Health Care Authority (OHCA).
(iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.
(iv) The exception for the trust continues after the disabled individual reaches age ~~65~~sixty-five (65). However, any addition or augmentation after age ~~65~~sixty-five (65) involves assets that were not the assets of an individual under age ~~65~~sixty-five (65); therefore, those assets are not subject to the exemption.
(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of ~~65~~sixty-five (65).
(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food~~, clothing~~ and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food~~, clothing,~~ or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food~~, clothing,~~ or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.
(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.
(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.
(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services~~ (HR&MS)~~, explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also

required. Health Related and Medical Services (HRMS) notifies Oklahoma Health Care Authority/Third Party Liability (OHCA/TPL) to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The ~~Trust~~trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to ~~3%~~three percent (3%) of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her

representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. ~~Health Related and Medical Services~~HRMS notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the OKDHS and may not be amended without the permission of the OKDHS;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of ~~30%~~thirty percent (30%) of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs ~~(BIA)~~.** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income

on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.