

Oklahoma Health Care Authority

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

OHCA COMMENT DUE DATE: January 16, 2019

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

Reference: APA WF 18-12

SUMMARY:

TEFRA Policy Update – The proposed revisions will amend Tax Equity and Fiscal Responsibility Act (TEFRA) policy by removing references to the Oklahoma Department of Human Services and replacing them with the Oklahoma Health Care Authority.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.150; 42 CFR 435.1009; 42 CFR 483.440

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Ivoria Holt
Federal and State Policy

FROM: Harvey Reynolds
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 18-12

A. Brief description of the purpose of the rule:

The proposed revisions to the Tax Equity and Fiscal Responsibility Act (TEFRA) policy and the policy entitled

"Determining categorical relationship to the disabled", will remove references to "OKDHS worker" and "local county office" and replace it with "the Oklahoma Health Care Authority (OHCA)" in those instances when the policy is referencing the TEFRA program or the Level of Care Evaluation Unit (LOCEU) at OHCA. TEFRA applications are currently processed entirely by the OHCA. Additionally, the revisions remove a section entitled "Specialist's examination" because the policy is obsolete.

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

The class of persons most affected by the proposed rule will most likely be TEFRA applicants as these rules should clear up confusion about which agency processes TEFRA applications. No information on any cost impacts were received from any entity.

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

The proposed rule change will benefit TEFRA applicants as these rules should clear up confusion about which agency processes TEFRA applications.

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

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

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

Agency staff has determined that the proposed rule change will be budget neutral.

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

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

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

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

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

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

- I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should not have any effect on the public health, safety or environment. The proposed rule is not designed to reduce significant risks to the public health, safety or environment.

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

The agency does not anticipate any detrimental effect on the public health, safety or environment if the proposed rule is not implemented.

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

Prepared date: October 18, 2018

RULE TEXT:

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she 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 ~~12~~twelve (12) months.

(1) **Determination of categorical relationship to the disabled by SSASocial Security Administration (SSA)**. The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) **Already determined eligible for Social Security disability benefits**. If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) **Already determined eligible for SSISupplemental Security Income (SSI) on disability**. If the applicant, under age ~~65~~sixty-five (65), states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to

establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) **Pending SSI/SSA application or has never applied for SSI.** If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal. Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of ~~12~~twelve (12) months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) **Already determined ineligible for SSI.** If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing

of the Title XIX application.

(E) **Already determined ineligible for Social Security disability benefits.** If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, ~~TPQY~~third party query procedure (TPQY) is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) **Determined retroactively eligible for SSA/SSI due to appeal.** If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within ~~12~~twelve (12) months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) **SSA/SSI appeal with benefits continued.** A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is

upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) **Applicant deceased.** Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two (2) months after hospital release. The details of the verification used are recorded in the case record.

(2) Determination of categorical relationship to the disabled by the LOCEU.

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

- (i) have been determined ineligible by SSA on some condition of eligibility other than disability,
- (ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or
- (iii) do not have a disability which would normally be expected to last ~~12~~twelve (12) months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last ~~12~~twelve (12) months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local ~~OKDHS~~DHS office is responsible for submitting a medical social summary on ~~OKDHS~~DHS form ABCDM-80-D 08MA022E with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and ~~OKDHS~~DHS Form 08MA005E are not normally considered pertinent medical information by themselves. Current (less

than ~~90~~ninety (90) days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of ~~OKDHS~~DHS form 08MA016E, Authorization for Examination and Billing. The ~~OKDHS~~DHS worker sends the 08MA016E and ~~OKDHS~~DHS form 08MA080E, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

~~(IV) Authorizing specialists' examinations as needed.~~

~~(V) Setting a date for re-examination, if needed.~~

~~(ii) **Specialist's examination.** If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.~~

~~(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible for making the decision regarding the request. If additional medical services are authorized, another Form M-S-32 will be completed.~~

~~(II) If the individual notifies the worker at least 24twenty-four (24) hours prior to the date of the examination that he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.~~

~~(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.~~

~~(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason must be supported by an affidavit signed by someone other than the individual or his/her representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.~~

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the countyOklahoma Health Care Authority (OHCA) uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/IIDs, or inpatient acute care hospital stays expected to

last not less than ~~60~~sixty (60) days. In addition to disability, LOCEU determines the appropriate level of care and cost effectiveness.

(3) **Determination of categorical relationship to the disabled based on TBTuberculosis (TB) infection.** Categorical relationship to disability is established for individuals with a diagnosis of ~~tuberculosis (TB)~~TB. An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(4) **Determination of categorical relationship to the disabled for TEFRA.** Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under ~~19~~nineteen (19) years of age, living at home who are disabled as defined by the ~~Social Security Administration~~SSA, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of ~~60~~sixty (60) days), nursing facility or intermediate care facility for individuals with intellectual disabilities, is determined eligible using only his/her income and resources as though he/she were institutionalized.

317:35-5-4.1. Special level of care and cost effectiveness application procedures for TEFRATax Equity and Fiscal Responsibility Act (TEFRA)

(a) In order for a child to be eligible for TEFRA, he/she must require a level of care provided in an acute care hospital for a minimum of ~~60~~sixty (60) days, or a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICFIID) for a minimum of ~~30~~thirty (30) days. It must also be appropriate to provide care to the child at home. The level of care determination is made by LOCEU. The level of care certification period may be for any number of months that the LOCEU determines appropriate. At the time of application, an assessment form is provided to the applicant for completion by the child's physician. Once completed by the physician and returned to the ~~OKDHS worker~~Oklahoma Health Care Authority, the assessment form is forwarded to the LOCEU along with the request for a disability determination (if needed).

(b) The estimated cost of caring for the child at home must not exceed the estimated cost of treating the child within an institution at the appropriate level of care, i.e., hospital, NF, or ICF/IID. The initial cost analysis is established by LOCEU based on the information provided by the TEFRA-1 Assessment form, ~~OKDHS worker~~, and medical information used in the relationship to disability determination.

(c) The level of care determination and cost effectiveness analysis are reported by LOCEU annually.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-49. Determination of income and resources for categorical relationship to ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA)

Countable income and resources for a child categorically related to disability for TEFRA are determined in accordance with rules for individuals determined aged, blind, or disabled (see ~~0A~~Oklahoma Administrative Code 317:35-5-41 through 317:35-5-41.11, 317:35-5-42, and 317:35-7-36). ~~Income and resources may not exceed the maximum standards as shown on OKDHS Appendix C-1, Schedules VIII. B. and D.~~The family is required to declare their household income so that the Oklahoma Health Care Authority may determine if the child qualifies for the TEFRA program or is otherwise SoonerCare eligible.

SUBCHAPTER 7. MEDICAL SERVICES

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-61.1. Special redetermination procedures for ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA)

In addition to redetermining the level of care annually, the OHCA also conducts an annual cost effectiveness review for all active TEFRA children. ~~The local county office is notified of the results of the review for any necessary case action.~~ If OHCA determines the child does not meet any level of care, is no longer disabled, or the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.