OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
September 12, 2013 at 1:00 P.M.
The Oklahoma Health Care Authority
Ponca Conference Room
2401 NW 23rd, Suite 1A
Oklahoma City, Oklahoma

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of August 21-23, 2013 OHCA Board Minutes

3. Discussion Item – Reports to the Board by Board Committees

    a) Strategic Planning Committee – Vice Chairman Armstrong

Item to be presented by Nico Gomez, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

    a) Medicaid Director's Update – Garth Splinter, State Medicaid Director

    b) All Stars Introduction – Nico Gomez, Chief Executive Officer

        - January – Suzie Megehee, DP Analyst/Planning Specialist III, Contractor Systems (Kyle Janzen)
        - June – Canielle Preston, Child Health Services Coordinator II, Health Promotion & Community Relations Services (Ed Long)
        - July – Barbara Gibbons, Assistant Director of Governmental Affairs, Governmental Relations (Ed Long)

    c) Office Space Update – James Smith, Chief of Staff

Item to be presented by Howard Pallotta, Director of Legal Services

5. Announcements of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting.

Item to be presented by Cindy Roberts, Deputy CEO – Planning, Policy & Integrity Division

6. Action Item – Consideration and Vote of Agency Recommended Emergency Rulemaking Pursuant to Article I of the Administrative Procedures Act. The agency requests the adoption of the following Permanent Rules:

The following emergency rules HAVE NOT previously been approved by the Board.

A. AMENDING Agency rules at OAC 317:35-5-43 through 35-5-46, 35-6-1, 35-6-15, 35-6-35 through 35-6-37, 35-6-60.1, 35-6- 61, 35-7-48, 35-9-67, 35-10-10, 35-10-25, 35-10-26, 35-15-6, and 35-19-20 to implement Systems Simplification Implementation effective October 1, 2013, instead of January 1, 2014. Rules are also revised to delay periodic renewals that would fall during the period January – March, 2014 until April, 2014, and to delay the effective date of terminations of SoonerCare eligibility for reasons related to changes in household composition or income until April, 2014 when the agency is redetermining eligibility based on changes in circumstances from January to March, 2014. These emergency rule revisions allow the State to correct regulatory complications created by federal rules; they implement a waiver of the federal requirement that the State use two sets of financial eligibility rules for pregnant women and families with children from October 1, 2013 to March 31, 2014, thereby avoiding serious prejudice to the public interest.

Item to be presented by Chairman McFall

7. Discussion Item – Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4) and (7)

   a) Finalization of CEO Evaluation

8. Action Item – Election of the Oklahoma Health Care Authority 2014 Board Officers

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
October 10, 2013
Oklahoma Health Care Authority
Ponca Conference Room

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
August 21-23, 2013
Held at Quartz Mountain Resort Arts and Conference Center
Lone Wolf, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority as well as the meeting room door at Quartz Mountain Resort Arts and Conference Center on August 20, 2013, 1:00 p.m. Advance public meeting notice is provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on August 20, 2013, 12:30 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:05 p.m.

BOARD MEMBERS PRESENT:	Chairman McFall, Vice-Chairman Armstrong, Member Miller, Member Bryant, Member Robison
BOARD MEMBERS ABSENT:	Member McVay, Member Nuttle

OTHERS PRESENT:	OTHERS PRESENT:
Nicole Altobello, OHCA	David Crawford, OUHSC
Dana Northrup, OHCA	Tywanda Cox, OHCA
Shelly Patterson, OHCA	Marjorie Snyder, OHCA
Virginia Gurney, OHCA	Mary Brinkley, LeadingAge OK
Sylvia Lopez, OHCA	Patrick Schlecht, OHCA
Phil Woodward, OPHA	Mike Fogarty, General Public
Dan Arthrell, Community Serv.Council	Shana Davis, OHCA, NEOKCRC
Jerry Scherer, OHCA	Imtiaz Ahmed, OHCA
Joe Mecham, OHCA	Nelson Solomon, OHCA
David Dude, American Cancer Society	Travis Kirkpatrick, OHCA
Daryn Kirkpatrick, OHCA	Shari Murphree, Willow Crest Hospital
Casey Dunham, OHCA	Becky Moore, OAHCP
Melody Bays, OHCA	Bill Garrison, OHCA
Mike Herndon, OHCA	Will Widman, HP
Charles Brodt, HP	Jo Kilgore, OHCA
Don Henderson, Integris Enid	Heather Pike, OFN
Lauren Labeth, OFN	Wanda Felty, MATF
Linda Ehrhardt, OHCA	Melinda Snowden, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD JUNE 27, 2013.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION:	Member Robison moved for the approval of the June 27, 2013 board minutes. Vice-Chairman Armstrong seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member Bryant
BOARD MEMBERS ABSENT:	Member McVay, Member Nuttle

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Audit/Finance Committee
Member Miller reported that the Audit/Finance Committee did not meet. He noted that our finances are in good shape. He wanted to call attention to the financial report regarding the accounts receivable of $20 million which was a timing issue due to agencies not receiving their state allocation of money until the second Tuesday of the month. So when we closed out on June 30th, they had not received their allocation but Member Miller has been reassured everything is now current.

Strategic Planning Committee
Vice-Chairman Armstrong stated that the committee did meet and discussed a number of items that will be included in the remainder of the board and retreat meeting.

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Nico Gomez, Chief Executive Officer

4a. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the final report for fiscal year 2013. She stated that we are under budget by $43 million state dollars, that's 2.8 percent of our Medicaid program spending and 10.3 percent in our administrative spending. Looking to fiscal year 2014, we are under budget. For a detailed financial report, see Item 4a of the August 21, 2013 board packet.

4b. MEDICAID DIRECTOR'S UPDATE
Garth Splinter, State Medicaid Director

Dr. Splinter reviewed the Medicaid Director's Report and noted the net increase of about 3,000 members and is up to 814,000 members in the program. Dual eligibles trended up slightly to 108, 648 for enrollment and the Long-Term Care program continues to be at 15, 500 for enrollees and $3,500 per member per month. The total provider enrollment is at 38,500 with 30,000 being in-state providers. Dr. Splinter noted that the mental health providers have nearly doubled the monthly average from last year and are up to 6,700 enrolled. The dental providers are at 1,400 enrollees and continue to grow. He stated that patient-centered medical home is growing with enrollment at 2,100. Dr. Splinter commented on the per member per month trends that reflects the core work of the agency and success that we achieve in the managed care efforts that we do. He said that over $118 million has been paid out under the electronic health records incentive program.

Vice-Chairman Armstrong asked Dr. Splinter if the hospital reduction of ten percent was due to closures, non-compliance, etc. Dr. Splinter will ask staff to go back historically and will gather that data. He will have an answer at the next board meeting. For more detailed information, see Item 4b of the August 21, 2013 board packet.

Mr. Gomez made an announcement that Chairman Ed McFall has been reappointed to the OHCA board another four years, by our current Speaker T.W. Shannon. He noted that it is great to have that experience for the state and to OHCA and congratulated Chairman McFall.

ITEM 5 / PRESENTATION BY DR. DONNA SPENCER, SENIOR RESEARCH ASSOCIATE, DEPUTY DIRECTOR & DR. KATHLEEN THIEDE CALL, PROFESSOR AND DGS OF STATE HEALTH ACCESS DATA ASSISTANCE CENTER (SHADAC) & UNIVERSITY OF MINNESOTA, SCHOOL OF PUBLIC HEALTH
Buffy Heater, Planning and Development Manager

(SHADAC) staff reported their findings from the 2013 Oklahoma Health Insurance Survey. This included interim results on the current status of Oklahomans sources of health insurance coverage, be it private, public or uninsured. For more detailed information, see Item 5 of the August 21, 2013 board packet.

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Howard Pallotta, General Counsel

Mr. Pallotta stated that there were no conflicts.

ITEM 7 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTLIZATION REVIEW BOARD UNDER TITLE 63 § 5030.3.
Nancy Nesser, Pharmacy Director

Action Item – Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under Title 63 § 5030.3

a) Consideration and vote to add **Oxtellar XR™ (Oxcarbazepine ER); Sabril® (Vigabatrin); Kynamro™ (Mipomersen); Vecamyl™ (Mecamylamine);** and **Fulyzaq™ (crofelemer)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION:	Vice Chairman Armstrong moved for approval of Item 7 as presented. Member Bryant seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member Robison
BOARD MEMBERS ABSENT:	Member McVay, Member Nuttle

ITEM 8 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4), (7) and (9)
Howard Pallotta, General Counsel

Discussion Item – Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B) (1), (4), (7) and (9).

a) Discussion of Pending Litigation, Investigations and Claims

MOTION:	Chairman McFall moved to go into executive session.
FOR THE MOTION:	Vice Chairman Armstrong, Member Miller, Member Robison, Member Bryant
BOARD MEMBERS ABSENT:	Member McVay, Member Nuttle

RECESS

RECONVENED BOARD MEETING/RETREAT AT 2:30PM, WEDNESDAY, AUGUST 21, 2013

THE FOLLOWING ITEMS WILL FOLLOW RETREAT FORMAT OF PANEL DISCUSSION AND OPEN DISCUSSION: ITEMS (9) THROUGH (21) ARE DISCUSSION ITEMS ONLY

9. *Wednesday: Session 1 (2:30-2:45pm)*
Welcome / Opening Remarks
- Ed McFall, OHCA Board Chairman
- Nico Gomez, CEO, OHCA

Mr. Gomez welcomed everyone for attending the Oklahoma Health Care Authority's 14th annual retreat. He mentioned the change in format from moving away towards a presentation style retreat and having

more of a conversational style. He noted that there will be a lot of exciting opportunities and he hopes everyone will be engaged in conversation.

Chairman McFall welcomed everyone's attendance and hoped for a productive meeting with attendees input, comments and ideas.

10. *Wednesday: Session 2 (2:45-3:00pm)*
OHCA Overarching Goals & Agenda Highlights

During this session we reviewed the agency's seven overarching goals, noted the mission statement, highlighted upcoming sessions during the retreat, and described the relationship between the agency's goals and session topics for this year's strategic planning activities.

Moderator:
- Cindy Roberts, Deputy CEO, Policy, Planning & Integrity, OHCA

11. *Wednesday: Session 3 (3:00-4:30pm)*
Goal #7 – Collaboration
To foster collaboration among public and private individuals and entities to build a responsive health care system for Oklahoma.

Partnering through collaboration has proven to be an effective strategy in meeting shared goals while affecting the health care of Oklahomans. Seeking to improve health outcomes for Oklahomans has resulted in multi-agency coordination and has evolved into identifying new ways of working together since there is overlap in many of the populations that are served by each entity. This session identified ways the OHCA may work with health care industries, state and local governments, educational facilities, private insurance companies, sovereign tribal nations, and commercial businesses to share in the common goal of Oklahoma being a healthy place to live, work and play. The availability of fewer resources has unquestionably encouraged the ability to leverage each other's resources and the coordination of efforts to meet common goals without duplicating efforts. We discussed the ways that collaboration among public and private sectors continues to be an integral part of the role of OHCA.

Moderator:
- Cindy Roberts, Deputy CEO, Policy, Planning & Integrity, OHCA

Panelists:
- Terry L. Cline, Oklahoma Secretary of Health, Commissioner, State Department of Health
- Nico Gomez, CEO, Oklahoma Health Care Authority
- Laura Brookins, Executive Director, Oklahoma Association of Health Plans
- Jenny Alexopulos, Center for Health Services, Oklahoma State University
- Lynn Mitchell, College of Medicine, University of Oklahoma
- Robyn Sunday-Allen, CEO, Oklahoma City Indian Clinic

12. *Wednesday: Session 4 (4:30-5:00pm)*
Last Call – Questions & Answers

This session provided an opportunity for all retreat participants to ask questions and receive answers related to Wednesday's agenda topics.

RECESS

RECONVENE BOARD MEETING/RETREAT 8:30AM, THURSDAY, AUGUST 22, 2013

THE FOLLOWING ITEMS WILL FOLLOW RETREAT FORMAT OF PANEL DISCUSSION AND OPEN DISCUSSION: ITEMS (9) THROUGH (21) ARE DISCUSSION ITEMS ONLY

13. *Thursday: Session 5 (8:30-8:45am)*
Welcome (8:30-9:00am)

- Ed McFall, OHCA Board Chairman
- Nico Gomez, CEO, OHCA

14. *Thursday: Session 6 (8:45-11:45am)*
Goal #2 – Program Development
To ensure that medically necessary benefits and services are responsive to the health care needs of our members

The OHCA has a longstanding history of maintaining focus on programs and services to better the health of our SoonerCare population. Many different initiatives have aimed to improve the health outcomes for hundreds of thousands of individuals served by the SoonerCare program. This session focused on the many different ways that OHCA manages the care of our most vulnerable members; the various services effectively serving members; and the opportunity for the OHCA to work with others to promote excellence in the OHCA programs. Attendees had the opportunity to view the most recent "Tell Us Your Story" video segments featuring two SoonerCare members and their experience with OHCA programs. For more detailed information, please see slides located at www.okhca.org.

Moderator

- Ed Long, Director of Communications

Panelists

- Garth Splinter, State Medicaid Director
- Steven Buck, Deputy Commissioner of Communications and Prevention, Department of Mental Health and Substance Abuse Services
- Becky Pasternik-Ikard, Deputy State Medicaid Director
- Sylvia Lopez, Chief Medical Officer
- Leon Bragg, Chief Dental Officer
- Alison Martinez, Geneticist

15. *Thursday: Session 7 (1:00-3:00pm)*
Goal #3 – Personal Responsibility
To educate and engage members regarding personal responsibilities for their health services utilization, behaviors, and outcomes

Poor health outcomes can only be improved when people take personal responsibility for their health habits. Being healthy involves making good choices about exercise, diet, preventive medical care and other behaviors. OHCA seeks to ensure members are taking personal responsibility for their health by focusing on utilization of services, by providing access to preventive and early intervention services and by guiding members as they navigate the health care delivery maze. OHCA also helps providers educate members on how to lead more healthy lifestyles, like being more active and eating healthier. This session featured three commercial segments recently created by the OHCA to educate Oklahomans on the importance of their engagement in their health care decisions. During this time, ideas were gathered about ways to raise awareness in members about the responsibilities they have in improving their health and make healthy choices. Additionally, this session sought answers to questions such as "how can OHCA financially incent certain behaviors?" and "how might OHCA work in concert with other entities to share best practices and achieve common objectives?" For more detailed information, please see slides located at www.okhca.org.

Moderator:

- Buffy Heater, Director of Planning & Performance

Panelists:

- Ed Long, Director of Communications
- Julie Cox-Kain, Oklahoma State Department of Health

- Tracey Strader, Executive Director, Tobacco Settlement Endowment Trust
- Jim Cacy, University of Oklahoma, Department of Family and Preventive Medicine
- Nancy Nesser, Pharmacy Director

16. *Thursday: Session 8 (3:00-4:30pm)*
Goal #4 – Satisfaction and Quality
To protect and improve member health and satisfaction, as well as ensure quality, with programs, services and care

This session explained what OHCA is doing to improve satisfaction and quality for SoonerCare members. The OHCA has a history developing and implementing successful initiatives focused on improving the overall health and satisfaction of SoonerCare members. At this session we learned about new innovations we are pursuing to meet this goal, charting a course for the future by developing quantifiable measures, and provide input on areas in which we need more information and can strive to do better. The OHCA is shaping a health care delivery system focused on improving quality by keeping people healthy through managing and preventing the occurrence of disease. This session highlighted recent independent evaluation efforts underway including the Primary Care Medical Home Evaluation, the Health Management Program Evaluation, and the Oklahoma Family Network Focus Groups. Additionally, the Adult Clinical Quality initiative provided perspective on future plans for obtaining valuable information on adult health improvements. For more detailed information, please see slides located at www.okhca.org.

Moderator:
- Sylvia Lopez, Chief Medical Officer

Panelists:
- Heather Pike, Administrative Director, Oklahoma Family Network
- Mike Herndon, Senior Medical Director
- Andrew Cohen, Founder and Corporate Director, Pacific Health Policy Group

17. *Thursday: Session 9 (4:30-5:00pm)*
Last Call – Questions & Answers
This session provided an opportunity for all retreat participants to ask questions and receive answers related to Thursday's agenda topics.

RECESS

RECONVENE BOARD MEETING/RETREAT 8:30AM, FRIDAY, AUGUST 23, 2013

THE FOLLOWING ITEMS WILL FOLLOW RETREAT FORMAT OF PANEL DISCUSSION AND OPEN DISCUSSION: ITEMS (9) THROUGH (21) ARE DISCUSSION ITEMS ONLY

18. *Friday: Session 10 (8:30-10:00am)*
Goal #5 – Eligibility and Enrollment
To provide and improve health care coverage to the qualified populations of Oklahoma

Oklahoma has historically struggled with health insurance coverage of its population, ranking among the lower third of the country among states. OHCA has been in the forefront on this issue and continues to work with state leaders to design fiscally sound programs that are sustainable. In this session, we reviewed the first formal evaluation of Oklahoma's nation-leading Online Enrollment (OE) system, published in May by Mathematica Policy Research. Operating since September of 2010, OE has been delivering instant, accurate eligibility determinations and has become a model for state Medicaid programs across the nation that are trying to modernize eligibility systems that otherwise employ numerous eligibility workers to process large volumes of paper applications. In addition, we examined enrollment processes as they exist today; how processes will change in the coming months as OHCA conforms to the changes federally mandated by the ACA; and how those changes will be communicated

to the public via federal and state efforts. The future ways a member will navigate the eligibility and enrollment systems to enroll in a program were discussed. We explored the future of eligibility and enrollment processes within Medicaid, and the anticipated interoperability with the Federally Facilitated Marketplace. For more detailed information, please see slides located at www.okhca.org.

Moderator:

- Becky Pasternik-Ikard, Deputy State Medicaid Director

Panelists:

- Derek Lieser, Director of Eligibility and Enrollment Automation
- Kevin Rupe, Director of Member Services
- John Giles, Oklahoma State Department of Health

19. *Friday: Session 11 (10:00-11:30am)*
Goal #1 – Financing and Reimbursement
To responsibly purchase cost effective health care for members by maintaining appropriate rates and to continue to strengthen health care infrastructure

The cost of healthcare is an issue that OHCA must deal with every day. OHCA faces the challenge of balancing the efficient use of resources with health care providers' need to cover expenses while keeping current with new medical practices and equipment and maintaining overall quality. Several topics have been of particular interest to our federal partner, CMS, including payment reform, value-based purchasing, shared savings, pay for performance and provider payment arrangements where rewards are given for meeting pre-established targets for exceptional delivery and positive outcomes. The OHCA continues to work with CMS and to seek innovative and cost effective ways to maintain a reliable and accessible provider network that serves as the backbone for the healthcare access to our members. During this session was discussion about strategies the OHCA is using to meet this goal. This session provided recent highlights from the efforts of the Patient Centered Medical Home program; representatives from the Health Access Networks shared their perspectives on the service they provide; and an update was provided on the Comprehensive Primary Care initiative (CPCi) by CMS to bring the avoidable cost down while improving health outcomes simultaneously. We discussed how OHCA is striving to be an effective and responsible purchaser of health care services while ensuring the provision of optimal health care to its members. For more detailed information, please see slides located at www.okhca.org.

Moderator:

- Carrie Evans, Chief Financial Officer

Panelists:

- Melody Anthony, Director of Provider and Medical Home Services
- Joseph Cunningham, BlueCross BlueShield, CPCi Collaborator
- Jack Sommers, Community Care, CPCi Collaborator
- Rosemary Klepper, Partnership for Healthy Central Communities Health Access Network, Canadian County
- Rachel Mix, OU Tulsa Health Access Network
- Mina Phillips, OSU Center for Health Services Health Access Network

20. *Friday: Session 12(11:30-12:00pm)*
Last Call / Open Forum / Action Plan Review

As a wrap-up to a full two and a half day agenda, and lots of issues discussed, this session was an opportunity to offer ideas to the agency as plans are made moving forward, as well as, questions and answers related to Friday's agenda topics. This time was specifically set aside to allow the OHCA to hear constructive suggestions on opportunities related to the seven OHCA goals mentioned on Wednesday's first session. Feedback helped the OHCA determine what could move the agency forward in the next

strategic planning period – 5 years – to achieve our vision for Oklahoman's to enjoy optimal health status through having access to quality health care regardless of their ability to pay.

Mary Brinkley discussed nursing home care and noted that a report came out that stated Oklahoma's nursing homes were rated 'F'. She noted that we have made great strides in Oklahoma as far as long term care but that we have some major problems to address. In 2004, legislation was passed that changed the way every Medicaid nursing home was reimbursed. Direct care staffing is the single most important determining factor of quality care in long term care. Ms. Brinkley stated that she thinks it's time we find a way to get a dedicated amount of money directed to long term care for nursing home rate increase. Some nursing homes have turnover in excess of 100 percent, which is unacceptable because you cannot provide quality care when you have that kind of turnover. She noted that OHCA has been a great supporter and great partner, but any further attention to long term care would be greatly appreciated. Vice-Chairman Armstrong noted that the patients that are currently being care for in nursing homes are at a much higher acute level of management of chronic diseases than they have been historically. One of the biggest determinations for having a good long term care facility experience is having family involved in the care and treatment of those individuals.

Wrap-up / Closing Remarks

- Ed McFall, OHCA Board Chairman

21 / NEW BUSINESS

There was no new business.

22 / ADJOURNMENT

MOTION:	Vice Chairman Armstrong moved for adjournment on August 23rd. Member Bryant seconded.
FOR THE MOTION:	Chairman McFall, Member Robison
BOARD MEMBERS ABSENT:	Member Miller, Member McVay, Member Nuttle

Meeting adjourned at 12:00 p.m., 8/23/2013

NEXT BOARD MEETING
September 12, 2013
Oklahoma Health Care Authority
Ponca Conference Room
2401 NW 23rd, Suite 1A
Oklahoma City, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

SoonerCare Programs

July 2013 Data for September 2013 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2013	Enrollment July 2013	Total Expenditures July 2013	Average Dollars Per Member Per Month July 2013
SoonerCare Choice Patient-Centered Medical Home			513,315	**540,164**	**$169,567,054**	
	Lower Cost	*(Children/Parents; Other)*		493,881	$121,587,527	$246
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		46,283	$47,979,527	$1,037
SoonerCare Traditional			217,231	**195,388**	**$211,157,163**	
	Lower Cost	*(Children/Parents; Other)*		87,769	$51,146,063	$583
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,619	$160,011,101	$1,487
SoonerPlan			48,346	**50,140**	**$974,175**	$19
Insure Oklahoma			30,202	**29,719**	**$9,644,042**	
	Employer-Sponsored Insurance		16,644	16,300	$3,647,469	$224
	Individual Plan		13,559	13,419	$5,996,573	$447
TOTAL			**809,094**	**815,411**	**$391,342,435**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $108,732,426 are excluded.

Net Enrollee Count Change from Previous Month Total	1,031

New Enrollees	21,208

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,110
Aged/Blind/Disabled	*Adult*	132,263
Other	*Child*	105
Other	*Adult*	20,814
PACE	*Adult*	125
TEFRA	*Child*	477
Living Choice	*Adult*	99
OLL Enrollment		**172,993**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2013	Enrolled July 2013
Dual Enrollees	**108,514**	**108,572**

		Monthly Average SFY2013	Enrolled July 2013
Long-Term Care Members		**15,674**	**15,477**
	Child	64	59
	Adult	15,610	15,418

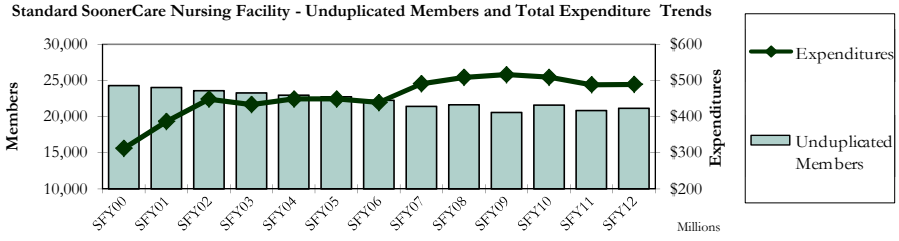
FACILITY PER MEMBER PER MONTH **$4,190**

SFY2012 Long-Term Care

Statewide LTC Occupancy Rate - 71.7%
SoonerCare funded LTC Bed Days 67.2%

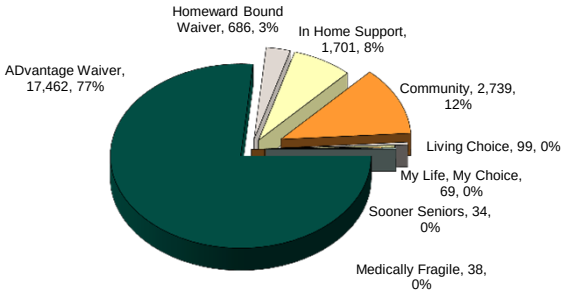
Data as of September 2012

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Nov. 19, 2012. Figures do not include intermediate care facilities for the intellectually disabled (ICF/ID).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the intellectually disabled (ICF/ID).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/ID.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/ID.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.
Sooner Seniors - This program is for adults 65 and older with long term illnesses who transitioned to community-based services in the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2013	Enrolled July 2013*
Total Providers		**36,948**	**36,588**
	In-State	28,587	28,188
	Out-of-State	8,362	8,400

*Effective July 2012, the methodology for counting providers has changed to count provider network. Previous counts include group practice and its members; the current count will include members only. Provider Network is providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types,

Program	% of Capacity Used
SoonerCare Choice	44%
SoonerCare Choice I/T/U	17%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2013	*Enrolled July 2013**	Monthly Average SFY2013	Enrolled July 2013
Physician	*7,859*	*8,163*	*12,432*	12,676
Pharmacy	*901*	*917*	*1,208*	1,239
Mental Health Provider**	*5,811*	*4,226*	*5,880*	4,256
Dentist	*1,205*	*1,267*	*1,380*	1,459
Hospital**	*194*	*183*	*923*	541
Optometrist**	*578*	*524*	*612*	550
Extended Care Facility	*362*	*359*	362	359

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers***	*4,997*	*5,225*	6,541	6,773
Patient-Centered Medical Home	*1,935*	*2,080*	1,985	2,160

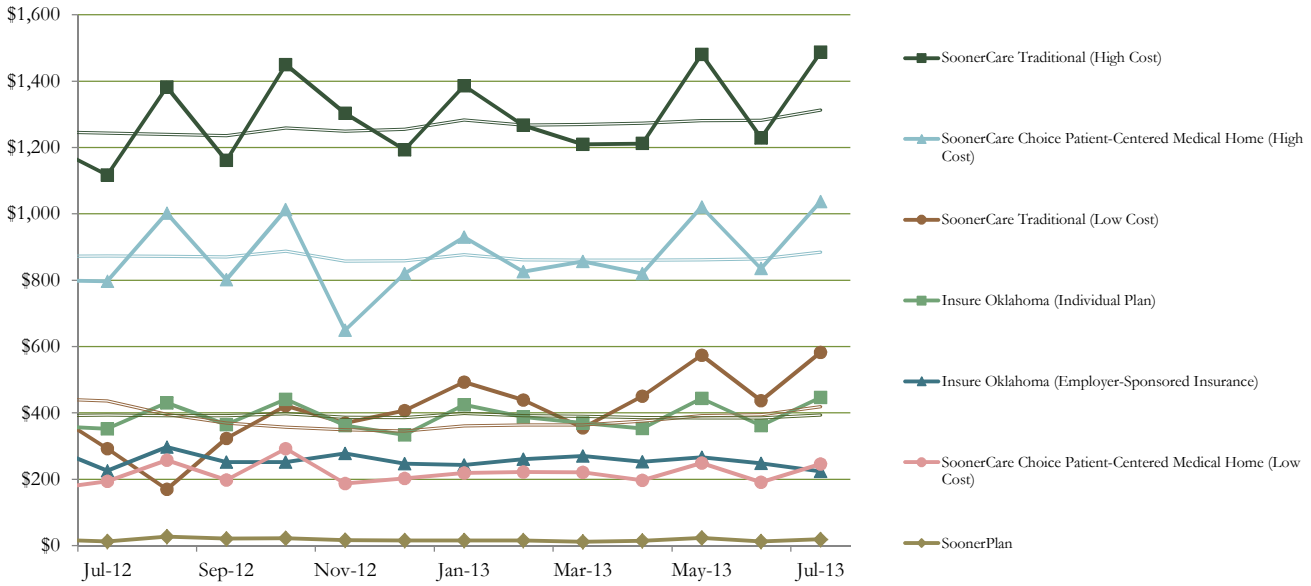
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

**Decrease in current month's count is due to contract renewal period which is typical during all renewal periods. Hospitals and Optometrists renewal started in March 2013 while renewal for Mental Health Providers started in June 2013.

Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. OHCA now directly contracts with providers that had previously billed through a group or agency.

SOONERCARE PER MEMBER PER MONTH (PMPM) TRENDS



In November and December 2012, there was a large increase in Patient-Centered Medical Home enrollment and related decrease in Traditional enrollment due to system changes.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

As Of 9/3/2013	August 2013		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	60	$688,500	1,770	$40,332,501
Eligible Hospitals	1*	$120,000	90	$78,693,319
Totals	61	$808,500	1,860	$119,025,820

*Current Eligible Hospitals Paid
PRAGUE COMMUNITY HOSPITAL

September 2013 Board Meeting

SOONERCARE CONTRACTED HOSPITALS

Hospitals in Oklahoma are required by state statute to be licensed except those hospitals operated by the federal government, state mental hospitals, and community-based structured crisis centers.

The Oklahoma State Department of Health (OSDH) uses the following categories for hospitals:

1) General Medical Surgical Hospital – A hospital maintained for the purpose of providing medical and surgical care in a broad category of illness and injury. These were matched to SoonerCare 'Acute Care' Hospitals.*

2) Critical Access Hospital – A hospital that the OSDH determines to be a necessary provider of healthcare services to residents of a rural community. These were matched to SoonerCare 'Critical Access' Hospitals.*

For the (1) General Medical Surgical Hospitals and (2) Critical Access Hospitals, payment for admissions for all covered inpatient services rendered to SoonerCare members are made based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. For each SoonerCare member's stay, a peer group base rate is multiplied by the relative weighting factor for DRG which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases.

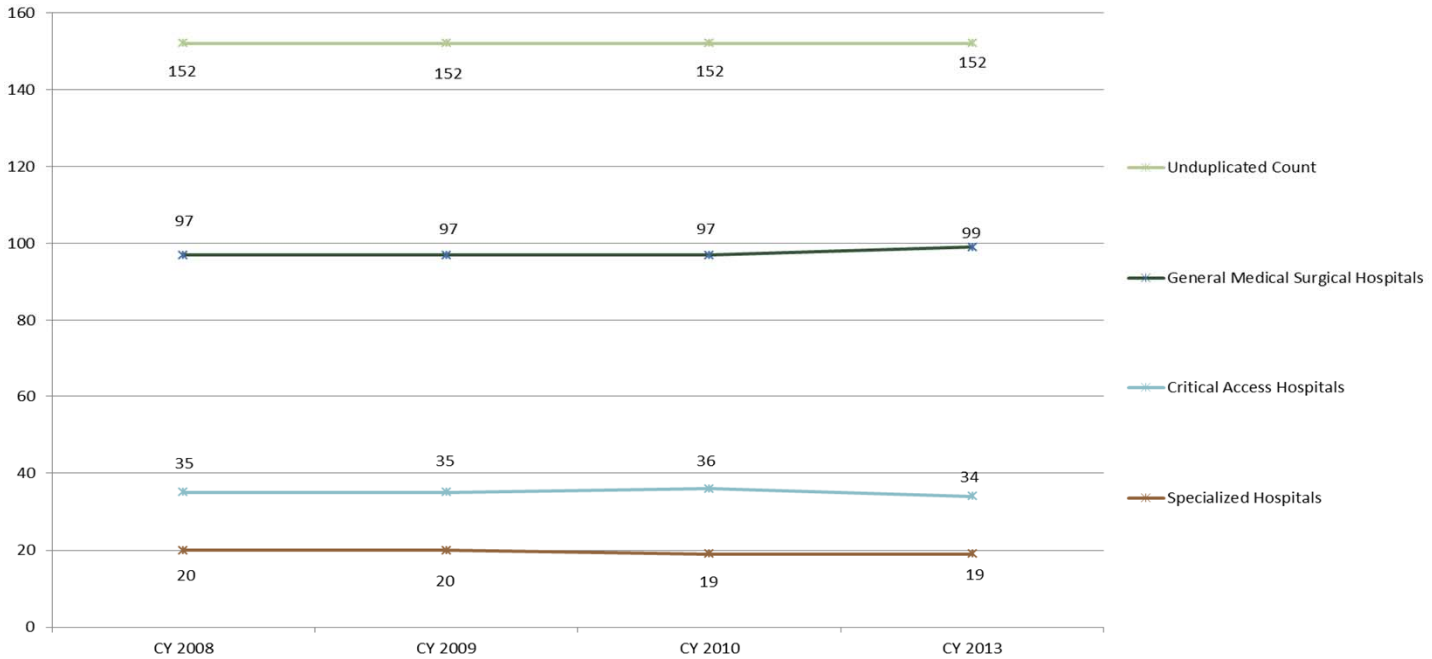
3) Specialized Hospital – A hospital maintained for the purpose of providing care in a certain category, or categories, of illness and injury. The OSDH currently recognizes psychiatric, rehabilitation, and abortion facilities as specialized hospitals. These were matched to the remaining SoonerCare Hospital Types: 'Children's Specialty', 'IHS Hospital', 'Psychiatric', 'Rehabilitation' and 'Residential Treatment Center.*

The (3) Specialized Hospitals (Freestanding Rehabilitation Hospitals, Freestanding Psychiatric Hospitals and Psychiatric Residential Treatment Facilities (PRTFs)) are paid a predetermined statewide per diem payment. Rates vary for public and private providers.

IHS Facilities are also paid a predetermined statewide per diem payment. The per diem amount is set by the Office of Management and Budget (OMB) annually and is the same for all members regardless of their level of care.

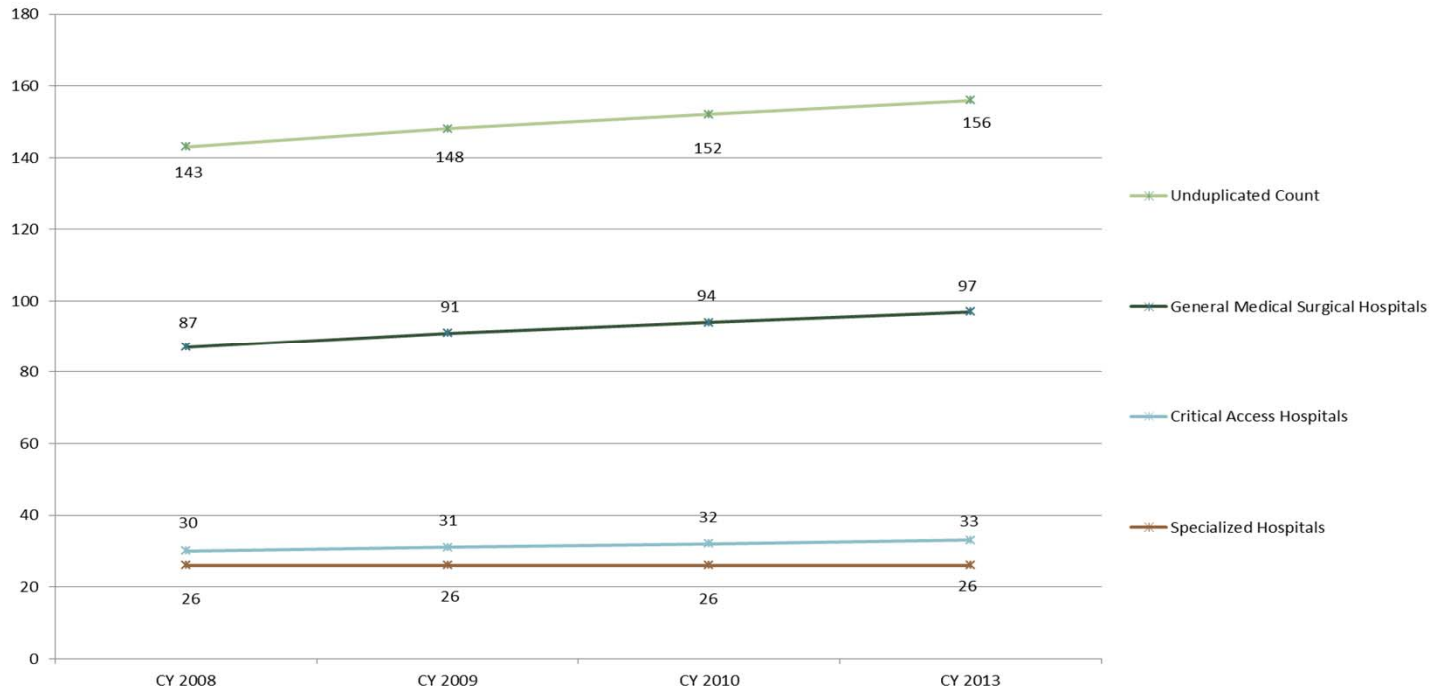
*A few hospitals were changed in the CY2008 - 2013 data below to match OSDH's Medical Facilities Service report from August 2013

Oklahoma State Department of Health Licensed In-State Hospitals



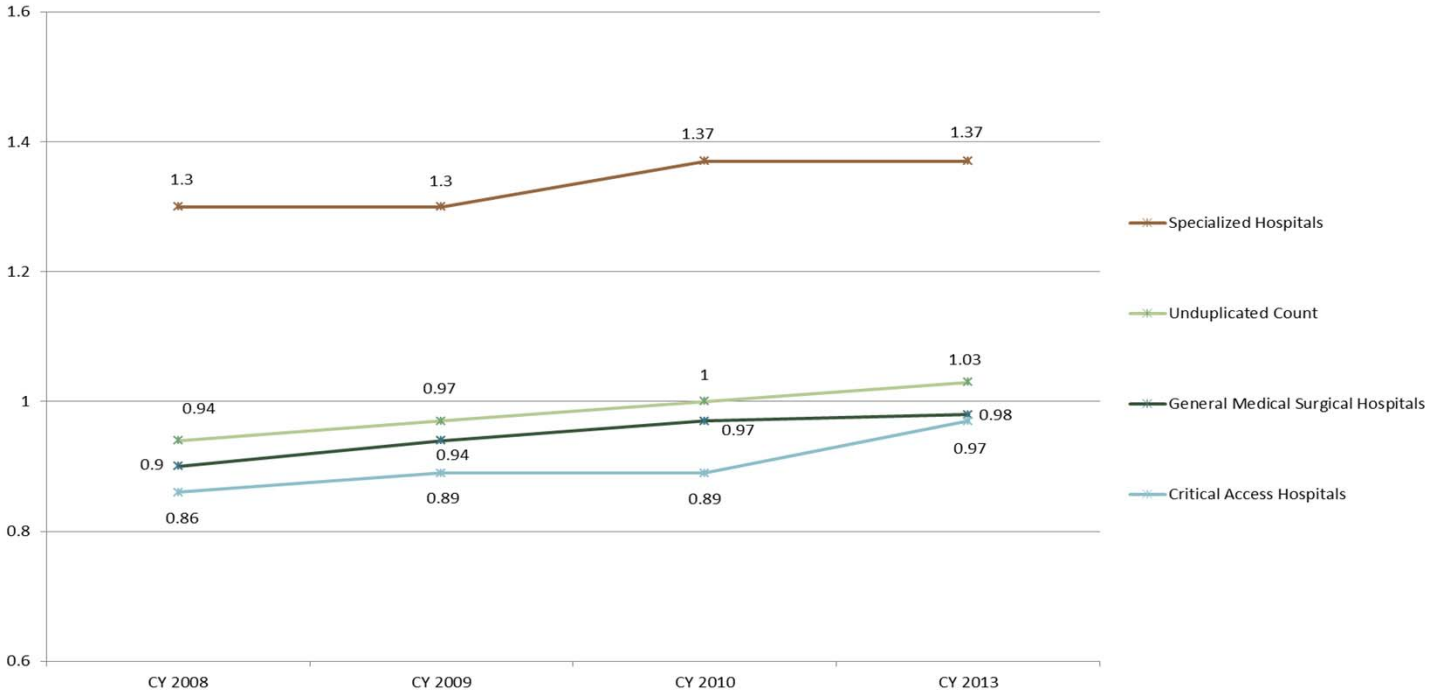
OSDH counts for CY 2008 to 2010 are from their annual reports found on their website (CY2010/2011 report only had 2010 counts): http://www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Facility_Services_Division/Hospital_Annual_Report/index.html. CY 2013 is from Aug 2013 Medical Facilities Service Report: http://www.ok.gov/health2/documents/MFS%20Directory.Eff.08.19.13.pdf. CY 2011 and 2012 data was not available.

SoonerCare Licensed In-State Hospitals



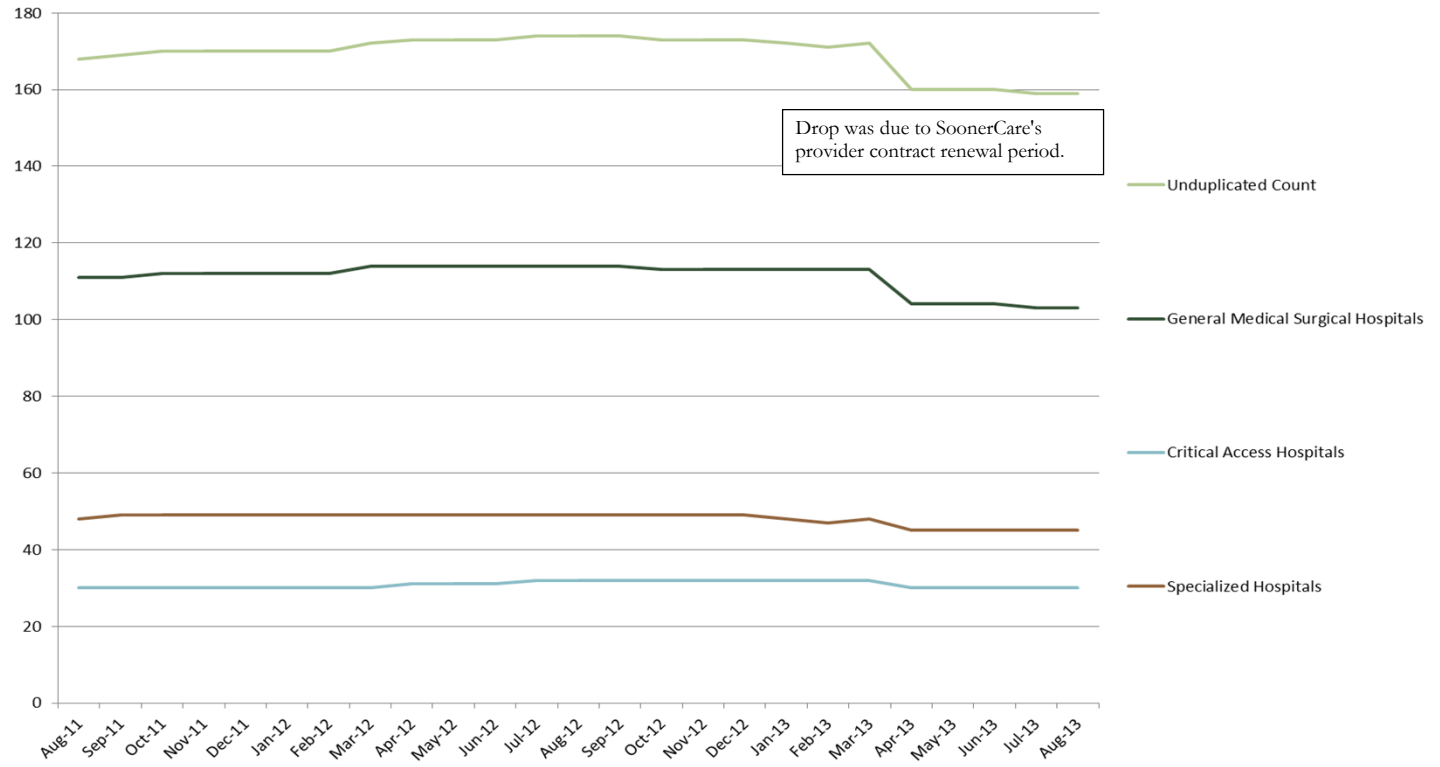
SoonerCare Licensed In-State Hospitals were counted by Provider ID only. Multiple locations in the state were excluded (Hospital was only counted once). A few Provider IDs had same License and also same or similar name as another Hospital so they were removed. SoonerCare Hospital data (License and then Name/Address if needed) was matched to OSDH's Medical Facilities Service report from August 2013 in order to group hospitals by same hospital type: http://www.ok.gov/health2/documents/MFS%20Directory.Eff.08.19.13.pdf. There were 13 hospitals that were not able to be matched by License or Name/Address so were placed under Specialized Hospitals. CY 2013 is January - August 2013. OHCA data as of 9/3/2013.

Ratio of In-State Licensed Hospitals between SoonerCare and OSDH



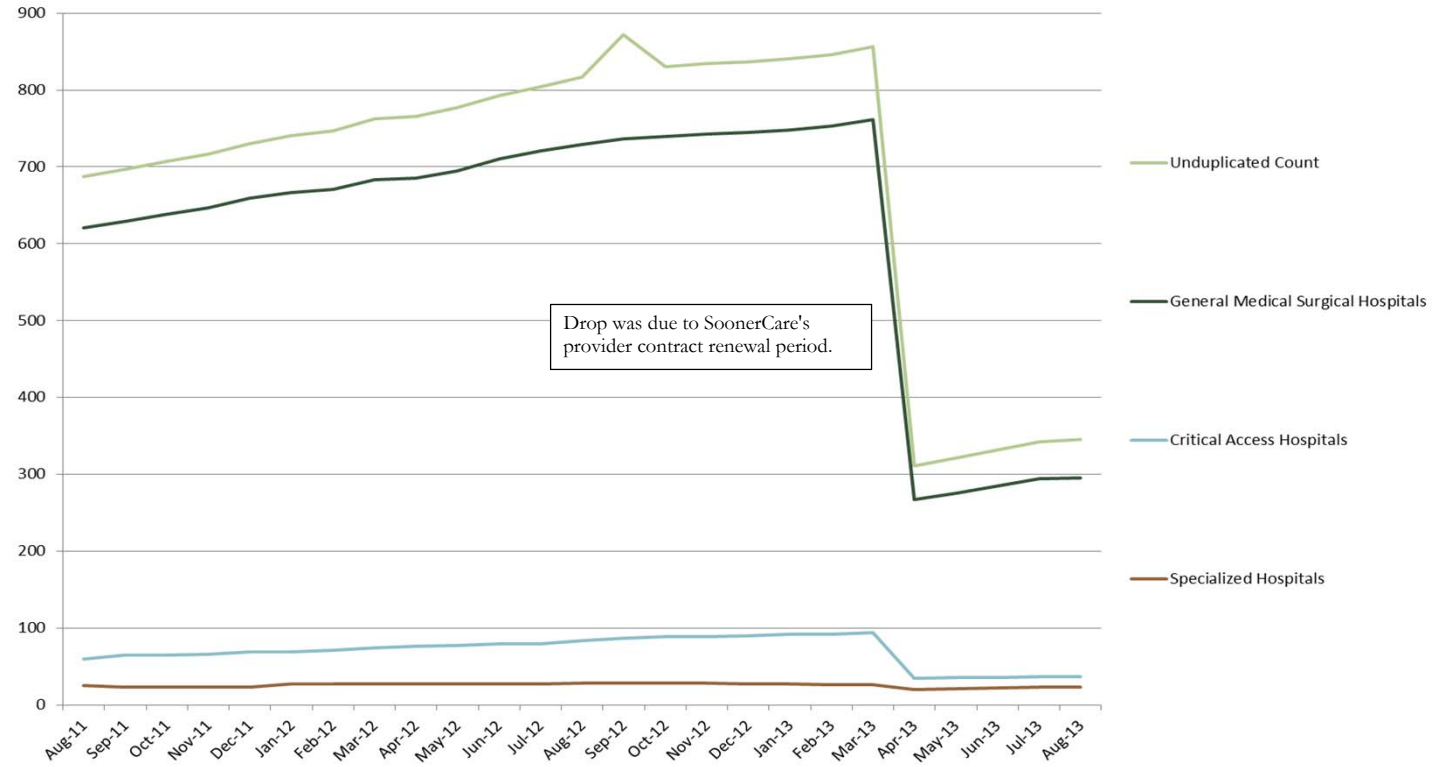
OHCA In-State Hospitals were counted by Provider ID only. Multiple locations in the state were excluded (Hospital was only counted once). A few Provider IDs had same License and also same or similar name as another Hospital so they were removed. OHCA Hospital data (License and then Name/Address if needed) was matched to OSDH's Medical Facilities Service report from August 2013 in order to group hospitals by same hospital type: http://www.ok.gov/health2/documents/MFS%20Directory.Eff.08.19.13.pdf. There were 13 hospitals that were not able to be matched by License or Name/Address so were placed under Specialized Hospitals. OHCA data as of 9/3/2013.

SoonerCare In-State Contracted Hospitals - August 2011 - August 2013



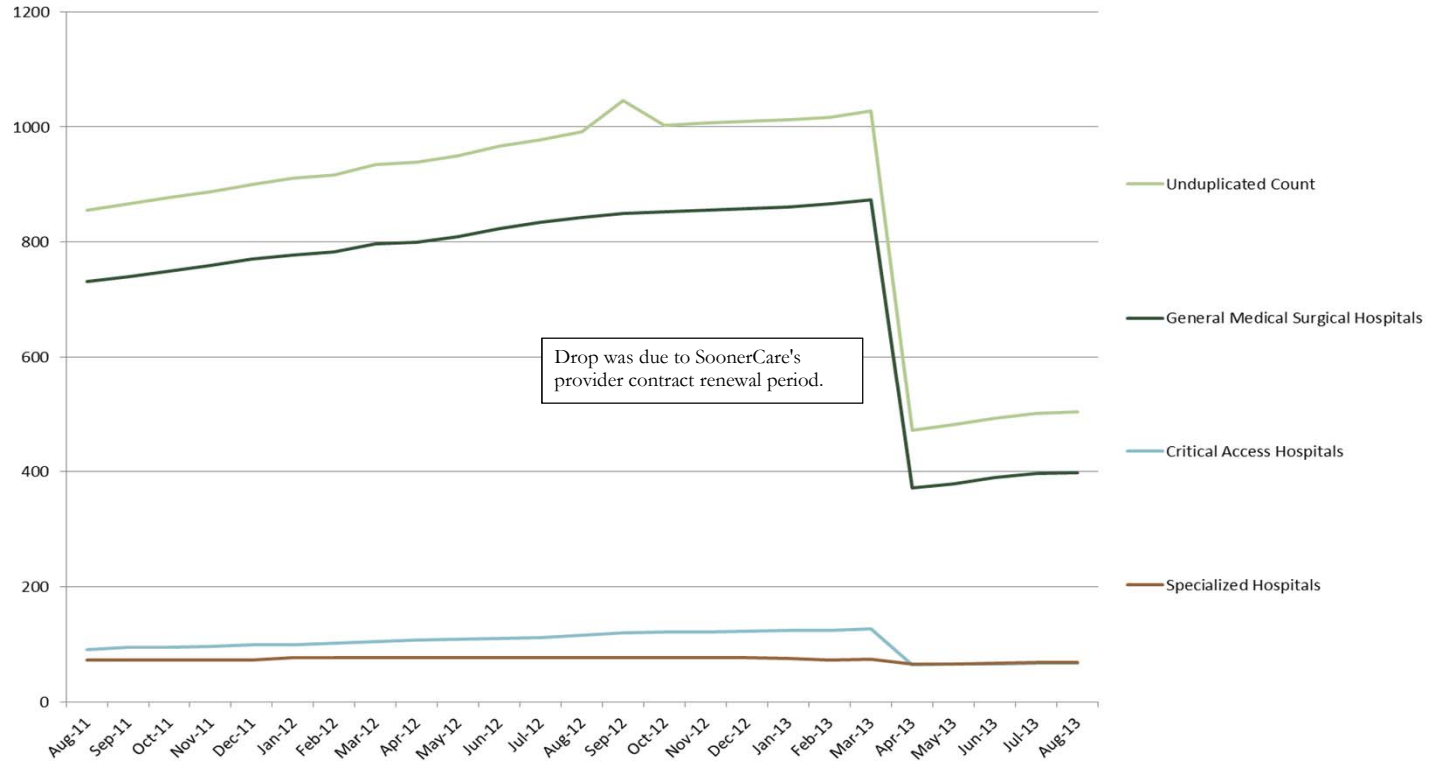
SoonerCare In-State Hospitals were counted by Provider ID only. Hospital Type was based on the Hospital's 'Specialty Code Field. 'Acute Care' Hospitals were grouped as 'General Medical Surgical Hospitals'. 'Critical Access' Hospitals were grouped as 'Critical Access Hospitals'. The remaining Hospital Types ('Children's Specialty', 'IHS Hospital', 'Psychiatric', 'Rehabilitation' and 'Residential Treatment Center') were grouped as 'Specialized Hospitals'. The drop in hospital providers in April 2013 is due to SoonerCare's provider contract renewal period. OHCA data as of 9/3/2013.

SoonerCare Out-of-State Contracted Hospitals - August 2011 - August 2013



SoonerCare Out-of-State Hospitals were counted by Provider ID only. Hospital Type was based on the Hospital's 'Specialty Code Field. 'Acute Care' Hospitals were grouped as 'General Medical Surgical Hospitals'. 'Critical Access' Hospitals were grouped as 'Critical Access Hospitals'. The remaining Hospital Types ('Children's Specialty', 'IHS Hospital', 'Psychiatric', 'Rehabilitation' and 'Residential Treatment Center') were grouped as 'Specialized Hospitals'. The drop in hospital providers in April 2013 is due to SoonerCare's provider contract renewal period. OHCA data as of 9/3/2013.

SoonerCare Total Contracted Hospitals - August 2011 - August 2013



SoonerCare Total Hospitals were counted by Provider ID only. Hospital Type was based on the Hospital's 'Specialty Code Field. 'Acute Care' Hospitals were grouped as 'General Medical Surgical Hospitals'. 'Critical Access' Hospitals were grouped as 'Critical Access Hospitals'. The remaining Hospital Types ('Children's Specialty', 'IHS Hospital', 'Psychiatric', 'Rehabilitation' and 'Residential Treatment Center') were grouped as 'Specialized Hospitals'. The drop in hospital providers in April 2013 is due to SoonerCare's provider contract renewal period. OHCA data as of 9/3/2013.


MIDWEST
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DEMOLITION


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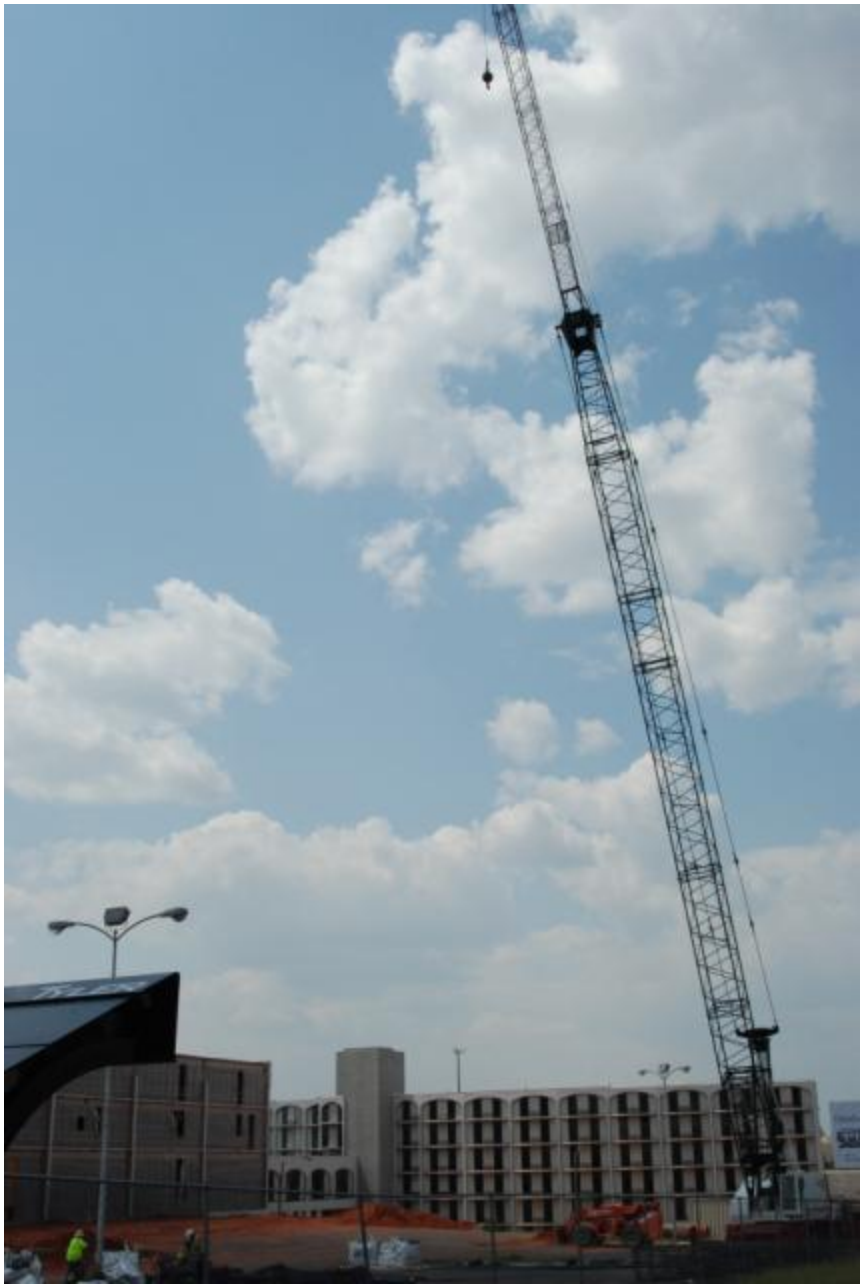


Future Home of
Oklahoma Health Care Authority
Construction By:
Financed By:
SNB
Architectural Design By:
Development By:
TANENBAUM

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 RELATIONSHIP

317:35-5-7. Determining categorical relationship to the children and parent and caretaker relative groups

(a) **Categorical relationship.** All individuals under age 19 are automatically related to the children's group and further determination is not required. Adults age 19 or older are related to the parent and caretaker relative group when there is a minor dependent child(ren) in the home and the individual is the parent, or is the caretaker relative other than the parent who meets the proper degree of relationship. A minor dependent child is any child who meets the AFDC eligibility requirements of age and relationship.

(b) **Grandfathered CHIP children.** As provided in OAC 317:35-6-1, the MAGI methodology is not applied to determine eligibility for children who are enrolled in SoonerCare on December 31, 2013 until March 31, 2014 or the child's next regularly scheduled renewal, whichever is later.

(1) The MAGI methodology eliminates the following income disregards, which are subtracted from gross income under the TANF methodology prior to ~~January~~October 1, ~~2014~~2013:

(A) The $240 work related expense deduction from earned income per employed household member;

(B) The disregard of the first $50 of child support received by a household; and

(C) The deduction for child support expenses paid by an employed parent or caretaker who needs child care in order to work, in the amount of the actual expense paid up to a maximum of $200 per month for children under 2 years of age and up to a maximum of $175 per month for children 2 years of age or older.

(2) If the elimination of the disregards listed in (1) when the MAGI methodology is applied to a child who was enrolled in SoonerCare on December 31, 2013 makes the child financially ineligible, the child is related to the Grandfathered CHIP children group.

(3) The following children are not eligible for the Grandfathered CHIP Children group:

(A) Children who are eligible for SoonerCare through another eligibility group;

(B) Children who have other creditable health insurance coverage;

(C) Children who are inmates of public institutions or are

patients in institutions for mental disease; or

(D) Children who are eligible for coverage under a health plan offered to employees of the State of Oklahoma.

(4) If a child's eligibility in this group is redetermined during his/her certification period and the child is financially ineligible without regard to elimination of the disregards in (1), the child's benefits are closed using normal procedures.

(5) Eligibility for children in this group expires on the date of the child's next regularly scheduled recertification after the recertification for which the MAGI methodology was first used. This eligibility group terminates for all children December 31, 2015.

(c) **Requirement for referral to the Oklahoma Child Support Services Division (OCSS).** As a condition of eligibility, when both the parent or caretaker and minor child(ren) are receiving SoonerCare and a parent is absent from the home, the parent or caretaker relative must agree to cooperate with OCSS. However, federal regulations provide for a waiver of this requirement when cooperation with OCSS is not in the best interest of the child. OCSS is responsible for making the good cause determination. If the parent or caretaker relative is claiming good cause, he/she cannot be certified for SoonerCare in the parent and caretaker relative group unless OCSS has determined good cause exists. There is no requirement of cooperation with OCSS for child(ren) or pregnant women to receive SoonerCare.

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-43. Third party resources; insurance, workers' compensation and Medicare

Federal Regulations require that all reasonable measures to ascertain legal liability of third parties to pay for care and services be taken. In instances where such liability is found to exist after SoonerCare has been made available, reimbursement to the extent of such legal liability must be sought. The applicant or member must fully disclose to OHCA that another resource may be available to pay for care. If OKDHS obtains information regarding other available resources from a third party, the worker must complete OKDHS Form 08AD050E, and submit to OHCA, Third Party Liability Unit. Certification or payment in behalf of an eligible individual may not be withheld because of the liability of a third party when such liability or the amount cannot be currently established or is not currently available to pay the individual's medical expense. The rules in this Section also apply when an individual categorically related to pregnancy-related services plans to put the child up for

adoption. Any agreement with an adoption agency or attorneys shall include payment of medical care and must be considered as a possibly liable third party, regardless of whether agreement is made during prenatal, delivery or postpartum periods.

(1) **Insurance.**

(A) **Private insurance.** An individual requesting SoonerCare is responsible for identifying and providing information on any private medical insurance. He/she is also responsible for reporting subsequent changes in insurance coverage.

(B) **Government benefits.** Individuals requesting SoonerCare who are also eligible for Civilian Health and Medical Programs for Uniformed Services (CHAMPUS), must disclose that the coverage is available. They are considered a third party liability source.

(2) **Workers' Compensation.** An applicant for SoonerCare or a SoonerCare member that requires medical care because of a work injury or occupational disease must notify OHCA/TPL immediately and assist OHCA in ascertaining the facts related to the injury or disease (such as date, details of the accident, etc.). The OHCA periodically matches data with the Worker's Compensation Court on all cases under its jurisdiction. When any information regarding an applicant for SoonerCare or a SoonerCare member is obtained, the member must assist OHCA with the subrogation claim with the employer/insurer.

(3) **Third party liability (accident or injury).** When medical services are required for an applicant of SoonerCare or a SoonerCare member as the result of an accident or injury known to the worker, the member is responsible for reporting to OHCA/TPL the persons involved in the accident, date and details of the accident and possible insurance benefits which might be made available. If an automobile accident involves more than one car it is necessary to report liability insurance on all cars involved.

(A) If OKDHS receives information regarding a SoonerCare member or applicant seeking medical services due to an accident, the worker submits any information available to OHCA/TPL.

(B) If OHCA receives a claim for payment from SoonerCare funds and the diagnosis indicates the need for services may have resulted from an accident or injury involving third party liability, OHCA will attempt to contact the member to obtain details of the incident. If additional contact is necessary with the member, the local OKDHS office or OHCA representative may be requested by the OHCA/TPL Unit to submit the appropriate information.

(4) **Medicare eligibility.** If it appears the applicant may be eligible for Medicare but does not have a Medicare card or other verification, the information is cleared with the Social Security Office and the findings entered with the date of the verification in the record. If the applicant did not enroll for Part A or Part B at the time he/she became eligible for Medicare and is now subject to pay an escalated premium for Medicare enrollment, he/she is required to do so. Payment can be made for services within the scope of SoonerCare.

(5) **Absent parent.**

(A) Applicants are required to cooperate with the Oklahoma Department of Human Services Oklahoma Child Support Services (OCSS) in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind, or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The child support income continues to be counted in determining SoonerCare eligibility if it is counted under the financial eligibility methodology used for the group for which eligibility is being determined. The rules in OAC ~~317:10~~317:35-10 are used, with the following exceptions:

(i) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(ii) Prior to ~~January~~October 1, ~~2014~~2013, child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the CFSD or retained by the member. Effective ~~January~~October 1, ~~2014~~2013, see rules regarding financial eligibility for the individual's eligibility group to determine whether child/spousal support is counted as income.

(iii) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

(B) Cash medical support may be ordered to be paid to the

OHCA by the non-custodial parent if there is no access to health insurance at a reasonable cost or if the health insurance is determined not accessible to the child according to OCSS Rules. Reasonable is deemed to be 5% or less of the non-custodial parent's gross income. The administration and collection of cash medical support will be determined by OKDHS OCSS and will be based on the income guidelines and rules that are applicable at the time. However, at no time will the non-custodial parent be required to pay more than 5% of his/her gross income for cash medical support unless payment in excess of 5% is ordered by the Court. The disbursement and hierarchy of payments will be determined pursuant to OKDHS/OCSS guidelines.

317:35-5-44. Child/spousal support

The Omnibus Budget Reconciliation Act of 1987 requires the Oklahoma Department of Human Services to provide Child Support Services to certain families receiving SoonerCare benefits through the Oklahoma Child Support Services Division (OCSS). The families are required to cooperate in assignment of medical support rights. These families will not be required to cooperate with the OCSS in the assignment of child/spousal support rights. The families involved are those with a minor child(ren) in the home. The child(ren) must be related to the children's, the blind or the disabled groups and have a parent(s) absent from the home. Any support collected on behalf of these families will be paid to them as if they were receiving non-public assistance child support services, with one exception. The exception is regarding child support collected for foster care child(ren) in OKDHS temporary custody. This support is paid to OKDHS Children and Family Services Division (CFSD). The rules in OAC 317:10 are used, with the following exceptions:

(1) In the event the family already has an existing child support case, the only action required is a memo to the appropriate OCSS district office notifying them of the certification.

(2) Prior to ~~January~~October 1, ~~2014~~2013, child/spousal support is always counted as income less any applicable income disregard. This income inclusion applies whether it is redirected to the OCSS or retained by the member. Effective ~~January~~October 1, ~~2014~~2013, see rules regarding financial eligibility for the individual's eligibility group to determine whether child or spousal support is counted as income.

(3) Children who are in custody of OKDHS may be exempt from referral to OCSS. Should the pursuit of the OCSS services be

determined to be detrimental to the OKDHS CFSD service plan, an exemption may be approved.

317:35-5-45. Determination of income and resources for children and parents and caretaker relatives

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** Income is determined in accordance with OAC 317:35-10 for individuals categorically related to AFDC. Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification. Individuals categorically related to AFDC are excluded from the AFDC resource test. Certain AFDC rules are specific to money payment cases and are not applicable when only SoonerCare services are requested. Exceptions to the AFDC rules are:

(1) the deeming of the parent(s)' income to the minor parent;

(2) the deeming of the sponsor's income to the sponsored alien;

(3) the deeming of stepparent income to the stepchildren. The income of the stepparent who is not included for SoonerCare in a family case is not deemed according to the stepparent liability. Only the amount of the stepparent's contribution to the individual is considered as income. The amount of contribution is determined according to OAC 317:35-10-26(a)(8), Person acting in the role of a spouse;

(4) the AFDC lump sum income rule. For purposes of SoonerCare eligibility, a period of ineligibility is not computed;

(5) mandatory inclusion of minor blood-related siblings or minor dependent children. For SoonerCare purposes, the family has the option to exclude minor blood-related siblings and/or minor dependent children;

(6) the disregard of one half of the earned income;

(7) dependent care expense. For SoonerCare only, dependent care expenses may be deducted for an in-home provider who, though not approved, would have qualified had the qualification process been followed;

(8) AFDC trust rule. The availability of trusts for all SoonerCare only cases is determined according to OAC 317:35-5-41.6;

(9) AFDC Striker rules. Striker status has no bearing on SoonerCare eligibility;

(10) ET&E Sanction rule. The ET&E status has no bearing on SoonerCare eligibility. However, a new SoonerCare application is required.

(b) **Effective ~~January~~October 1, ~~2014~~2013.** Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to the children and parent and caretaker relatives groups. See Subchapter 6 of this Chapter

for MAGI rules.

317:35-5-46. Determination of income and resources for categorical relationship to pregnancy-related services

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** Countable income for an individual categorically related to pregnancy-related services is determined in the same manner as for an individual categorically related to AFDC. (See OAC 317:35-5-45). Eligibility is based on the income received in the first month of certification with changes in income not considered after certification. Individuals categorically related to pregnancy-related services are excluded from a resource test.

(b) **Effective ~~January~~October 1, ~~2014~~2013.** Income is determined in accordance with the Modified Adjusted Gross Income (MAGI) methodology for individuals related to the pregnancy group. See Subchapter 6 of this Chapter for MAGI rules. Eligibility is based on the income received in the first month of certification with changes in income not considered after certification, and there is no resource test.

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 for groups whose eligibility is determined using Modified Adjusted Gross Income (MAGI). These rules apply to the following groups:

(1) Children,
(2) Grandfathered CHIP children,
(3) Pregnant women,
(4) Pregnancy-related services under Title XXI,
(5) Parents and caretaker relatives,
(6) SoonerPlan Family Planning program,
(7) Independent foster care adolescents,
(8) Inpatients in public psychiatric facilities under 21, and
(9) Tuberculosis.

(b) See 42 CFR 435.603 to determine whether MAGI applies to a group not specifically listed in this Section.

(c) ~~MAGI rules are not applied to members enrolled in SoonerCare on December 31, 2013 until March 31, 2014, or the date of their next regularly scheduled renewal, whichever is later.~~MAGI rules take effect on October 1, 2013.

~~(d) For new applicants or individuals who have had a break in eligibility and are not enrolled on December 31, 2013, MAGI rules take effect on January 1, 2014.~~

PART 3. APPLICATION PROCEDURES

317:35-6-15. Application for SoonerCare for Pregnant Women and Families with Children; forms

(a) **Application**. An application for pregnant women and families with children 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 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, or online. A 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 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 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 days from the date services are rendered. The hospital, applicant, or someone acting on the applicant's behalf has fifteen days from the date the NODOS form was received by OHCA to submit a completed SoonerCare application. Filing a Notification of Date of Service does not guarantee coverage

and if a completed application is not submitted within fifteen 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 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 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

317:35-6-35. General eligibility consideration

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** Financial eligibility for SoonerCare Health Benefits for Pregnant Women and Families with Children is determined using the rules on income according to the category to which the individual is related. (See Part 5, Subchapter 5 of this Chapter.) Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification. There is not a resource test for individuals categorically related to AFDC or pregnancy related services.

(b) **Effective ~~January~~October 1, ~~2014~~2013.** Financial eligibility for SoonerCare Health Benefits for MAGI eligibility groups is determined using the MAGI methodology. Unless questionable, the income of individuals who are related to a MAGI eligibility group does not require verification. There is no resource test for individuals related to any of the MAGI groups (see Part 1 of this Subchapter for a list of the MAGI groups).

(c) When medical assistance is requested on behalf of any individual, eligibility is determined for that individual as well as all other individuals in the family unit who meet basic criteria for a SoonerCare eligibility group.

(d) Income is evaluated on a monthly basis for all individuals included in the case for Health Benefits.

317:35-6-36. Financial eligibility of individuals categorically related to AFDC or pregnancy-related services

(a) **Prior to ~~January~~October 1, ~~2014~~2013.** In determining financial eligibility for an individual related to AFDC or pregnancy-related services, 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:

(1) the individual;

(2) the spouse of the individual;

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

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

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

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

(b) **Prior to ~~January~~October 1, ~~2014~~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.

(c) **Effective ~~January~~October 1, ~~2014~~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) **Effective ~~January~~October 1, ~~2014~~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

Individuals whose income is less than the standards on DHS Appendix C-1 for the applicable eligibility group are financially eligible for SoonerCare.

(1) **Categorically needy standards/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 DHS Appendix C-1. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **Categorically needy standards/categorically related to children's and parent/caretakers' groups.**

(A) **Categorical relationship.** For the individual related to AFDC to be considered categorically needy, the standards on DHS Appendix C-1 schedules must be used.

(i) **DHS Appendix C-1, Schedule X.** Individuals age 19 years or older, other than pregnant women, are determined categorically needy if countable income is less than the Categorically Needy Standard, according to the family size. ~~Income standards are 73.1% of the AFDC Need Standard.~~

(ii) **DHS Appendix C-1, Schedule I.A.** All individuals under 19 years of age are determined categorically needy if countable income is equal to or less than the Categorically Needy Standard, according to the size of the family. ~~Income standards are 185% of Federal Poverty Level.~~

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

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

(ii) Individuals related to the children's or parent/caretakers' 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 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 caretaker relative.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60.1 Changes in circumstances

(a) **Reporting changes.** Members are required to report changes in their circumstances within 10 days of the date the member is aware of the change.

(b) **Agency action on changes in circumstances**. 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.

(c) **Changes reported by third parties.** When the agency receives information regarding a change in the member's circumstances from a third party, such as the Oklahoma Employment Security Commission (OESC) or the Social Security Administration (SSA), the agency will determine whether the information received is reasonably compatible with the most recent information provided by the member.

(1) If the information received is reasonably compatible with the information provided by the member, the agency will use the information provided by the member for determinations and redeterminations of eligibility.

(2) If the information received is not reasonably compatible with the information provided by the member, the agency will determine whether the information received will have an effect on the eligibility of any member of the household.

(A) If the information received has no effect on the eligibility of any member of the household, including the benefit package the member is enrolled in, the agency will take no action.

(B) If the information received has an effect on the eligibility of a member of the household, the agency will request more information from the member, including, but not limited to, an explanation of the discrepancy or verification documenting the correct information regarding the factor of eligibility affected by the information received from a third party.

(C) The agency will give the member proper notice of at least 10 days to respond to the agency's request for information.

(D) If the member does not cooperate in resolving the discrepancy within the timeframe established by the notice, benefits will be terminated.

(d) **Exception January to March, 2014.** During the period January to March, 2014, redeterminations due to changes in circumstances will be processed, but the effective date of any termination action taken as a result of changes in household composition or

income for individuals in MAGI eligibility groups will be April 1, 2014, or later.

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare

(a) A periodic redetermination of eligibility for SoonerCare is required for all members. The redetermination is made prior to the end of the initial certification period and each 12 months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

(b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.

(c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within 90 days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.

(d) Periodic redeterminations scheduled for January to March, 2014 will be rescheduled for April, 2014.

SUBCHAPTER 7. MEDICAL SERVICES
PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-48. Eligibility for the SoonerPlan Family Planning Program

(a) Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below the applicable standard on the OKDHS Appendix C-1. Prior to ~~January~~October 1, ~~2014~~2013, the standard deduction for work related expenses such as income tax payments, Social Security taxes, and

transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1). Effective ~~January~~October 1, ~~2014~~2013, MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.

(2) Prior to ~~January~~October 1, ~~2014~~2013, in determining financial eligibility for the SoonerPlan Family Planning program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. ~~January~~October 1, ~~2014~~2013, MAGI household composition rules are used to determine eligibility for SoonerPlan.

(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.

(4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning Program with the option of applying for SoonerCare at any time.

(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.

(b) All health insurance is listed on the OKDHS computer system in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.

(c) Income for the SoonerPlan Family Planning Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.

(d) There is not an asset test for the SoonerPlan Family Planning Program.

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-67. Determining financial eligibility of categorically needy individuals

Financial eligibility for ICF/MR, HCBW/MR, and individuals age 65 or older in mental health hospitals medical care for categorically needy individuals is determined as follows:

(1) **Prior to ~~January~~October 1, ~~2014~~2013, financial eligibility/categorically related to AFDC**. In determining

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

(A) spouse; and

(B) parent(s) and minor children of their own. Individuals related to AFDC but not receiving a money payment are not entitled to one-half income disregard following the earned income deduction.

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

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

(2) **Effective ~~January~~October 1, ~~2014~~2013, financial eligibility in a Modified Adjusted Gross Income (MAGI) eligibility group.** In determining financial eligibility for an individual related to a group for whom the MAGI methodology is used, rules in Subchapter 6 of this Chapter are followed.

(3) **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 individual's countable income must be less than the categorically needy standard as shown on the OKDHS Appendix C-1, Schedule VI. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering an ICF/MR, see OAC 317:35-9-68 (a)(3) to determine financial eligibility.

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

the categorically needy standard on OKDHS Appendix C-1, Schedule VI, is used. The rules on determination of income and resources are applicable only when an individual has entered an ICF/MR and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends [Refer to OAC 317:35-9-68 (a)(3)(B)(x)]. An individual who is a patient in an extended care facility may have SSI continued for a three month period if he/she meets conditions described in Subchapter 5 of this Chapter. The continuation of the payments is intended for use of the member and does not affect the vendor payment. If the institutional stay exceeds the three month period, SSI will make the appropriate change.

(B) In determining eligibility for HCBW/MR services, refer to OAC 317:35-9-68(b).

(C) In determining eligibility for individuals age 65 or older in mental health hospitals, refer to OAC 317:35-9-68(c).

(4) **Transfer of capital resources on or before August 10, 1993**. Individuals who have transferred capital resources on or before August 10, 1993 and are applying for or receiving NF, ICF/MR or HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this rule. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

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

(i) The transfer was prior to July 1, 1988.
(ii) The title to the individual's home was transferred to:
(I) the spouse;
(II) the individual's child under age 21 or who is blind or totally disabled;
(III) a sibling who has equity interest in the home and resided in the home for at least one year prior to the individual's admission to the nursing facility; or
(IV) the individual's son or daughter who resided in the home and provided care for at least two years prior to the individual's admission to the nursing facility.
(iii) The individual can show satisfactorily that the intent was to dispose of resources at fair market value or that the transfer was for a purpose other than eligibility.
(iv) The transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's resource allowance.
(v) The resource was transferred to the individual's child who is under 21 or who is blind or totally disabled.
(vi) The resource was transferred to the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the resources are not subsequently transferred to still another person for less than fair market value.
(vii) The denial would result in undue hardship. Such determination should be referred to OKDHS State Office, FSSD, Health Related and Medical Services, for a decision.

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

(C) The penalty period can be ended by either the resource being restored or commensurate return being made to the individual. The cost of care during the penalty period cannot be used to shorten or end the penalty period.

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

(E) The restoration or commensurate return will not

entitle the member to benefits for the period of time that the resource remained transferred. An applicant cannot be certified for NF, HCBW/MR, or ADvantage waiver services for a period of resource ineligibility.

(5) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

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

(B) For purposes of this paragraph, an "institutionalized" individual is one who is residing in an ICF/MR or receiving HCBW/MR services.

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

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

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

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

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

or

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

(F) A penalty would not apply if:

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

(I) the spouse;

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

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

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

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

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

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

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

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

the age of 65; or

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

(G) The individual is advised by a written notice of a period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

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

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

(J) The restoration or commensurate return will not entitle the member to benefits for the period of time that the asset remained transferred. An applicant cannot be certified for NF, ICF/MR, HCBW/MR, or ADvantage waiver services for a period of asset ineligibility.

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

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

(6) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

(B) For purposes of this paragraph, an "institutionalized"

individual is one who is residing in an ICF/MR or receiving HCBW/MR services.

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) when there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average monthly cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average monthly cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

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

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

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

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

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

(I) the spouse; or

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

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

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

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

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

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

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

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

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of ICF/MR or HCBW/MR services and the continuance of eligibility for other SoonerCare services.

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

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

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

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

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

(7) **Commensurate return.** Commensurate return for purposes of this Section is defined as actual money payment or documentation of money spent on the member's behalf; i.e.,

property taxes, medical debts, nursing care expenses, etc., corresponding to the market value of the transferred property. The definition does not include personal services, labor or provision of rent-free shelter. It also does not include a monetary value assigned and projected for future payment either by cash or provision of services. Any transfer of property within the five years prior to application or during receipt of assistance must be analyzed in regard to commensurate return as well as determination of intent.

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, or pregnancy eligibility groups, including pregnancies covered under Title XXI. Prior to ~~January~~October 1, ~~2014~~2013, the countable income generated from any resource is considered in accordance with Part 5 of this Subchapter. Effective ~~January~~October 1, ~~2014~~2013, countable income generated from any resource is considered in accordance with Part 6 of Subchapter 6 of this Chapter.

PART 5. INCOME

317:35-10-25. Income defined

Prior to ~~January~~October 1, ~~2014~~2013, income is defined as that gain, payment or proceed from labor, business, property, retirement and other benefits. Effective ~~January~~October 1, ~~2014~~2013, for MAGI eligibility groups as defined in OAC 317:35-6-1, income is defined by the Internal Revenue Code.

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, SoonerPlan, or Title XIX and XXI pregnancy eligibility groups 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 policy, is taken into

consideration in determining need. Income is considered available both when 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). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 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 SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit. Effective ~~January~~October 1, ~~2014~~2013, the MAGI methodology rules determine whose income is considered in a particular household for MAGI eligibility groups as defined in 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 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 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. 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 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) Prior to ~~January~~October 1, ~~2014~~2013, a nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to a member of the children, parent or caretaker relative, or pregnancy groups who is not currently eligible for SSI, is not counted as income. Effective ~~January~~October 1, ~~2014~~2013, 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) Prior to ~~January~~October 1, ~~2014~~2013, lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in

the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award. Effective ~~January~~October 1, ~~2014~~2013, 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. Effective ~~January~~October 1, ~~2014~~2013, 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 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 months, will be averaged and considered as income for the next six months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six 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. Effective ~~January~~October 1, ~~2014~~2013, 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 months to establish the amount to be anticipated and considered for prospective budgeting.

(6) Prior to ~~January~~October 1, ~~2014~~2013, a caretaker relative

can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. Effective ~~January~~October 1, ~~2014~~2013, MAGI household rules are used to determine whether a caretaker relative or stepparent is included in a household.

(A) Prior to ~~January~~October 1, ~~2014~~2013, consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children. However, if that person is the stepparent, the policy on stepparent liability is applicable. Effective ~~January~~October 1, ~~2014~~2013, 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) Prior to ~~January~~October 1, ~~2014~~2013, if a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month. Effective ~~January~~October 1, ~~2014~~2013, 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) Prior to ~~January~~October 1, ~~2014~~2013, a stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included. Effective ~~January~~October 1, ~~2014~~2013, 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) Prior to ~~January~~October 1, ~~2014~~2013, when there is a stepparent or person living in the home with the biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded

as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind. Effective ~~January~~October 1, ~~2014~~2013, 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. Prior to ~~January~~October 1, ~~2014~~2013, payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the wage prior to payroll deductions and/or withholdings. Effective ~~January~~October 1, ~~2014~~2013, 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 prior to ~~January~~October 1, ~~2014~~2013.** If the income results from the individual's activities primarily as a result of the individual's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of

labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income only if it is representative of the individual's current situation. The individual's business records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

(ii) If the self-employment enterprise has been in existence for less than a year, the income is averaged over the period of time the business has been in operation to establish the monthly income amount.

(iii) Self-employment income which represents an annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(B) **Items not considered**. The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from self-employment effective ~~January~~October 1, ~~2014~~2013.** 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.
(3) **Earned income from wages, salary or commission.** Prior to ~~January~~October 1, ~~2014~~2013, if the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income. Effective ~~January~~October 1, ~~2014~~2013, 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) **Earned income from work and training programs.** Prior to ~~January~~October 1, ~~2014~~2013,earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year. Effective ~~January~~October 1, ~~2014~~2013, countable income for MAGI eligibility groups is determined in accordance with MAGI income counting rules in Part 6 of Subchapter 6 of this Chapter.
(5) **Individual earned income exemptions prior to ~~January~~October 1, ~~2014~~2013.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.
(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group.
(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.
(i) Child care expense may be deducted when:
(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and
(II) the employed member whose income is considered must purchase care.
(ii) The actual amount paid for child care per month, up to a maximum of $200 for a child under the age of

two or $175 for a child age two or older may be deducted.

(iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider.

(iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.

(v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(6) **No individual earned income exemptions effective ~~January~~October 1, ~~2014~~2013.** 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 5% of the FPL for the individual's household size as defined in OAC 317:35-6-39.

(7) **Formula for determining the individual's net earned income prior to ~~January~~October 1, ~~2014~~2013.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(8) **Formula for determining the individual's net earned income effective ~~January~~October 1, ~~2014~~2013 for MAGI eligibility groups.** To determine net income, see MAGI rules in OAC 317:35-6-39.

(c) **Unearned income prior to ~~January~~October 1, ~~2014~~2013.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is

considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(d) **Unearned income effective ~~January~~October 1, ~~2014~~2013.** 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.

(e) **Income disregards prior to ~~January~~October 1, ~~2014~~2013.**

Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Education Grants (including work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of the loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;

(5) Indian payments (including judgment funds or funds held in trust) which are distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;

(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;

(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;
(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;
(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
(15) Earnings of a child who is a full-time student are disregarded;
(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;
(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;
(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;
(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;
(21) Payments made from the Agent Orange Settlement Fund or

any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;

(24) Interests of individual Indians in trust or restricted lands;

(25) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);

(26) Any payments made directly to a third party for the benefit of a member of the benefit group;

(27) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;

(28) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complimentary payments;

(29) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(30) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);

(31) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

(32) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

(33) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

(34) Wages paid by the Census Bureau for temporary employment related to Census activities.

(f) **Income disregards effective ~~January~~October 1, ~~2014~~2013.** 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) In computing monthly income, cents will be carried at all

steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two 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 2.

(4) **Biweekly.** Income received every two weeks is multiplied by 2.15.

SUBCHAPTER 15. PERSONAL CARE SERVICES

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/categorically related to AFDC prior to ~~January~~October 1, ~~2014~~2013.** In determining income for the individual related to AFDC, all family income is considered. (See OAC 317:35-5-45 for Exceptions to AFDC rules.) The "family", for purposes of determining need, includes the following persons if living together (or if living apart but there has been no break in the family relationship):

(A) spouse; and

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

(i) For adults, to be categorically needy, the net income must be less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule X.

(ii) For individuals under 19, to be categorically needy, the net income must be equal to or less than the categorically needy standard as shown on the OKDHS form 08AX001E (Appendix C-1), Schedule I. A.

(2) **Financial eligibility for MAGI eligibility groups effective ~~January~~October 1, ~~2014~~2013.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

(3) **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.

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

SUBCHAPTER 19. NURSING FACILITY SERVICES

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

Financial eligibility for NF medical care is determined as follows:

(1) **Financial eligibility/categorically related to AFDC prior to ~~January~~October 1, ~~2014~~2013.**

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

(i) spouse; and

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

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

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

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

(2) **Financial eligibility for MAGI eligibility groups effective ~~January~~October 1, ~~2014~~2013.** See MAGI eligibility rules in Subchapter 6 of this Chapter to determine financial eligibility for MAGI eligibility groups.

(3) **Financial eligibility/categorically related to ABD**. In determining income and resources for the individual related to ABD, the "family" includes the individual and spouse, if any. If an individual and spouse cease to live together for reasons other than institutionalization, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the spouse after the mutual consideration has ended are considered. If the individual and spouse cease to live together because of the individual entering a nursing facility, see paragraph (3) of OAC 317:35-19-21 to determine financial eligibility.

(A) The categorically needy standard on OKDHS Appendix C-1, Schedule VI., is applicable for individuals related to ABD. If the individual is in an NF and has received services for 30 days or longer, the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B.1., is used. If the individual leaves the facility prior to the 30 days, or does not require services past the 30 days, the categorically needy standard in OKDHS Appendix C-1, Schedule VI., is used. The rules on determination of income and resources are applicable only when an individual has entered a NF and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends.

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

(4) **Transfer of capital resources on or before August 10, 1993**. Individuals who have transferred capital resources on or before August 10, 1993 and applying for or receiving NF, ICF/MR, or receiving HCBW/MR services are subject to penalty if the individual, the individual's spouse, the guardian, or legal representative of the individual or individual's spouse, disposes of resources for less than fair market value during the 30 months immediately prior to eligibility for SoonerCare if the individual is eligible at institutionalization. If the individual is not eligible for SoonerCare at institutionalization, the individual is subject to penalty if a resource was transferred during the 30 months

immediately prior to the date of application for SoonerCare. Any subsequent transfer is also subject to this policy. When there have been multiple transfers of resources without commensurate return, all transferred resources are added together to determine the penalty period. The penalty consists of a period of ineligibility (whole number of months) determined by dividing the total uncompensated value of the resource by the average monthly cost to a private patient in a nursing facility in Oklahoma. The penalty period begins with the month the resource or resources were first transferred and cannot exceed 30 months. Uncompensated value is defined as the difference between the equity value and the amount received for the resource.

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

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

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

(I) the spouse;

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

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

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

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

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

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

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

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

(B) The individual is advised by a written notice of a

period of ineligibility due to transfer of assets. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

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

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

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

(5) **Transfer of assets on or after August 11, 1993 but before February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after August 11, 1993 but before February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this paragraph subjects the individual to a penalty period for the disposal of such assets.

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

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

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

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

received for the resource.

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

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

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

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

(F) A penalty would not apply if:

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

(I) the spouse;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) **Transfer of assets on or after February 8, 2006.** An institutionalized individual, an institutionalized individual's spouse, the guardian or legal representative of the individual or individual's spouse who disposes of assets on or after February 8, 2006 for less than fair market value on or after the look-back date specified in (A) of this

paragraph subjects the individual to a penalty period for the disposal of such assets.

(A) For an institutionalized individual, the look-back date is 60 months before the first day the individual is both institutionalized and has applied for medical assistance. However, individuals that have purchased an Oklahoma Long-Term Care Partnership Program approved policy may be completely or partially exempted from this Section depending on the monetary extent of the insurance benefits paid.

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

(C) The penalty period will begin with the later of:

(i) the first day of a month during which assets have been transferred for less than fair market value; or

(ii) the date on which the individual is:

(I) eligible for medical assistance; and

(II) receiving institutional level of care services that, were it not for the imposition of the penalty period, would be covered by SoonerCare.

(D) The penalty period:

(i) cannot begin until the expiration of any existing period of ineligibility;

(ii) will not be interrupted or temporarily suspended once it is imposed;

(iii) When there have been multiple transfers, all transferred assets are added together to determine the penalty.

(E) The penalty period consists of a period of ineligibility determined by dividing the total uncompensated value of the asset by the average cost to a private patient in a nursing facility in Oklahoma shown on OKDHS Appendix C-1. In this calculation, the penalty must include a partial month disqualification based upon the relationship between that fractional amount and the average cost to a private patient in a nursing facility in Oklahoma. There is no limit to the length of the penalty period for these transfers. Uncompensated value is defined as the difference between the fair market value at the time of transfer less encumbrances and the amount received for the resource.

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

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

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

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

(G) Special Situations.

(i) Separate Maintenance or Divorce.

(I) There shall be presumed to be a transfer of assets if an applicant or member receives less than half of the couple's resources pursuant to a Decree of Separate Maintenance or a Decree of Divorce.

(II) There shall be presumed to be a transfer of assets if the income is reduced to an amount lower than the individual's own income plus half of the joint income. The transfer penalty shall be calculated monthly.

(III) Assets which were exempt lose the exempt character when not retained by the applicant or member in the divorce or separate maintenance. These assets, if received by the other spouse, are counted when determining the penalty.

(IV) The applicant or member may rebut the presumption of transfer by showing compelling evidence that the uneven division of income or resources was the result of factors unrelated to SoonerCare eligibility.

(ii) Inheritance from a spouse.

(I) Oklahoma law provides that a surviving spouse is entitled to a minimum portion of a deceased spouse's probate estate. The amount depends on several factors.

(II) It is considered a transfer if the deceased spouse's will places all, or some, of the statutory share the applicant or member is entitled to receive in a trust which the applicant or member does not have unfettered access to or leaves less than the statutory amount to the applicant or member, who does not then elect to receive the statutory share in probate proceedings.

(H) A penalty would not apply if:

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

(I) the spouse;

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

Security;

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

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

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

(iii) the transfer was to the community spouse or to another person for the sole benefit of the community spouse in an amount equal to the community spouse's asset allowance. "Sole benefit" means that the amount transferred will be used for the benefit of the community spouse during his or her expected life.

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

(v) the asset was transferred to or from the spouse (either community or institutionalized) or to another person for the sole benefit of the spouse if the assets are not subsequently transferred to still another person for less than fair market value. "Sole benefit" means that the amount transferred will be used for the benefit of the spouse (either community or institutionalized) during his or her expected life.

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

(vii) the denial would result in undue hardship. Undue hardship exists when application of a transfer of assets penalty would deprive the individual of medical

care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(I) An undue hardship does not exist if the individual willingly transferred assets for the purpose of qualifying for SoonerCare services through the use of the undue hardship exemption.

(II) Such determination should be referred to OKDHS State Office for a decision.

(III) If the undue hardship exists because the applicant was exploited, legal action must be pursued to return the transferred assets to the applicant before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(I) The individual is advised by a written notice of a period of ineligibility due to transfer of assets, a timely process for determining whether an undue hardship waiver will be granted and a process for an adverse determination appeal. The notice explains the period of ineligibility for payment of NF and the continuance of eligibility for other SoonerCare services.

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

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

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

(M) Assets which are held by an individual with another person or persons, whether held in joint tenancy or tenancy in common or similar arrangement, and the individual's ownership or control of the asset is reduced or eliminated is considered a transfer. The exception to this rule is if ownership of a joint account is divided according to the amount contributed by each owner.

(i) Documentation must be provided to show each co-owner's contribution;

(ii) The funds contributed by the applicant or SoonerCare member end up in an account owned solely by the applicant or member.

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

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