JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
September 11, 2013
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St, Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the July 18, 2013 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion

a. 90 Day Referral Requirements (Dr. Crawford would like it discussed)

IV. Financial Report: Gloria Hudson, Director, General Accounting;
Vickie Kersey, Director, Fiscal Planning & Procurement

a. June Financial Summary
b. June Financial Detail Report
c. FY'14 Budget

V. SoonerCare Operations Update: Mary Triplet, Assistant Director, Member Services

a. SoonerCare Programs Report

VI. Action Items; Melinda Jones, Assistant Director, Health Policy

a. Workfolder 13-08; Systems Simplification Implementation
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.

b. Workfolder 13-16: Insure Oklahoma— Insure Oklahoma (IO) rules are revised to align with the Special Terms and Conditions of the Section 1115 Demonstration Waiver. In accordance with waiver special terms and conditions, the federal government has approved a one year (calendar) extension of the IO program. Rules are revised to remove Individual Plan children (while retaining Employer Sponsored Insurance (ESI) children) and limit adult Individual Plan enrollment to persons with household income at or below 100 percent of FPL. Revisions also include changes to the Individual Plan copayment structure; copayments cannot exceed current federal maximums with the exception of emergency room (ER) visits in which case the existing copay for ER visits will remain at $30.00. **Budget Impact:** Budget Neutral

VII. New Business

VIII. Adjourn

Next Meeting: Thursday, November 21, 2013

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
MINUTES
JULY 18, 2013

Members present: Ms. Bellah, Ms. Bierig, Ms. Behr for Ms. Brinkley, Ms. Case, Dr. Cavallaro, Dr. Crawford, Ms. Davis, Ms. Felty, Ms. Fritz, Ms. Galloway, Mr. Goforth, Dr. Grogg (via teleconference), Ms. Holiman-James, Mr. Jones, Dr. Post, Dr. Rhoades, Dr. Rhynes, Dr. Simon, Mr. Rains for Ms. Slatton-Hodges/Ms. White, Dr. Wright

OHCA Chief Medical Officer: Sylvia Lopez, M.D.

Members absent: Dr. Bourdeau, Mr. Clay, Ms. Mays, Dr. McNeill, Dr. Ogle, Mr. Patterson, Mr. Pilgrim, Mr. Tallent, Dr. Wells, Ms. Wheaton, Dr. Woodward

I. Welcome, Roll Call, and Public Comment Instructions

Chairman Crawford called the meeting to order. There was no public comment. A moment of silence was observed in respect of Board Chairman Ed McFall's wife Rose Anna, who recently passed.

Dr. Crawford addressed the structure and bylaws of the MAC. Each organization has designated a delegate and an alternate. We have had some organizations that have followed those rules and these are bylaws agreed to by the MAC. We now have some organizations submit names that have not been properly vetted. They have not been designated as the alternate.

Dr. Crawford questioned the MAC members - The statement was made that we have bylaws. Should we follow those in regards to strict adherence to the delegate and alternate, and, if they send a non-delegate or non-alternate, should we have those people sit and represent? They can make comments in the public comments section regarding issues associated with what is before us each meeting, but do they have a voting capability? The MAC is an advisory committee, and not rigid, but the Board does listen to the MAC and would like to know their opinion based on votes of the representatives of the designated individuals, and those representing particular organizations.

The MAC members agreed to adhere by the bylaws. Only the named designee or alternate is to be the representative on the MAC.

Ms. Holiman-James introduced, and the MAC welcomed, her new alternate, Ms. Debra Booten-Hiser.

II. Approval of minutes of the March 13, 2013 Medical Advisory Committee Meeting

Dr. Post approved. Ms. Holiman-James seconded. Motion carried.

III. MAC Member Comments/Discussion

There were no comments.

IV. Legislative Update: Carter Kimble, Governmental Affairs

Mr. Kimble reviewed the Legislative Update, and thanked Ms. Barbara Gibbons, who does the constituent relations and bill tracking, and Ms. Holli Eller, for keeping on track with the bills. All of the rules were approved. Starting next year, legislature has created an omnibus rule package process. There is no more passive approval. No actions still meant our rules were approved in the past. Going forward they will have to include all of our rules which will go into a single omnibus process which will go into a single resolution.

We asked for $40 million in new money this year, and were approved for $39.7 million. 10% of the funds go to the Woodwork Effect people who are currently eligible but who are not enrolled.

Valiant efforts to salvage the Insure Oklahoma program were not successful.

The SHOPP bill was extended from 2014 to 2017.

Dr. Crawford commented about an article on the news where two legislators proposed that if the Governor calls a special session that she wants on tort reform, it will try to address the issue on Insure Oklahoma. Mr. Kimble replied that our understanding is, in order for the Governor to call a special session, she has to outline what they are coming back for. Once they are back, they can bring anything up that they want to. We would be very surprised if they were called back for Insure Oklahoma.

V. Financial Report: Gloria Hudson, Director of General Accounting

A. April Financial Summary
B. April Financial Detail Report

Ms. Hudson reviewed the financial reports. There were no questions.

VI. SoonerCare Operations Update: Della Gregg, Manager, Health Management Program

A. SoonerCare Programs Report
B. HMP Update

Ms. Gregg presented the reports. There were no questions on the SC Programs Report.

Regarding the HMP Update, questions arose regarding the use of health coaches in practices and the main diagnoses. OHCA will use coaches in 35-40 practices. The majority are adults (87%), and the top diagnoses are diabetes and psychosis. The coaches are registered nurses. The unique part of this program is we did not look for diabetics, people with congestive heart failure. We looked for people who needed help, regardless of the diagnosis.

Dr. Wright commented that this gives hope on expanding the program, and Dr. Crawford stated In the debate that may go on regarding the Medicaid expansion issue, this type of program should get great publicity. This is saving money in the long run.

VII. Disaster Relief Efforts for Members: Ed Long and Marlene Asmussen

Mr. Long and Ms. Asmussen presented the report. Assistance was provided to our members and providers who were impacted from the recent tornadoes for their needs, including ways to get members to their appointments; prior authorizations for misplaced medications, and went above and beyond some non-traditional methods of support. Member Services developed a process to identify member calls of persons in the affected areas, to expedite those calls and to make sure they were triaged. Dr. Crawford commended the OHCA for their disaster relief efforts.

VIII. Living Choice Update: Erin Jackson

Ms. Jackson presented the report. A question was asked about housing. We partnered with the housing agency in order to open various opportunities for individuals without a house.

IX. Leavitt Report: Buffy Heater
A. Recommendations
B. Insure Oklahoma Update

Ms. Heater provided an update to the MAC. Leavitt found widespread support and we are doing things well. They like the way that we engage broad groups of stakeholders, the MAC especially. They saw the agency recognizes comments and incorporates them into a feedback loop. They loved our online enrollment process, Medical Home, the fact that we were nearly at 100% of Medicare rates in our provider reimbursements. They also acknowledged that our program accuracy rates were exceptional. They also loved that we controlled costs. They would like to see improvement for multiple committees regarding feedback to the board, and improved data reporting of HEDIS and CAHPS measures. This could be expanded. Leavitt suggested exploring options, competition with insurance. One of the ways they pointed out that we are able to do that is through passage of legislation last session which directed us to do a feasibility study for somewhat of a managed care component for our dual eligibles. That was a step in the right direction, to be mindful of the things that are going on in our state and across the nation, and to keep ourselves apprised and make sure we are doing the best job possible in our service delivery.

A question was asked regarding exploring competition, and if there was any analysis to study the current state of the insurance market as it compared to when we had a capitated model, and if it has changed any. Ms. Heater replied that Leavitt did take a look, and in the full report they provided a historical analysis that started prior to 1990 moving forward, and took it in three year segments. It was a good way for them to portray, recognize and learn, that the years in which we had managed care we saw initial savings, an increase in expenditures overall, and with the discontinuance of managed care, how these costs came back in line, and now we are right around the national average with expenditures. They were an objective evaluator.

The Oklahoma Plan - Leavitt based their recommendations and set the stage with a scary story, so to speak. As indicated on the slide, it shows the probability for people to be at risk of either risky behaviors or poor health outcomes, depending on their income. For those individuals with an annual wage of less than $25,000.00, their risk factor for being smokers, or having diabetes, or heart disease, asthma, being obese, the rates are in the 10, 20, 30, 40 percent. As a person who has lower income is at higher probability of having the high cost afflictions from a medical standpoint, compared to those with an annual wage of more than $50,000.00, the numbers drop off. Leavitt pointed out, it's to set the stage of why Oklahoma should be concerned with an Oklahoma plan, and why we should worry about providing additional coverage or why this

should be a topic of interest for our state. They said people in poverty, by nature of them being lower income, in our state, are much more at risk to have these risky behaviors. It had more to do with an individual's income status than it did with their health coverage status. In Oklahoma, it is not only an issue with health insurance coverage, but is also an issue of socioeconomic status, it has to do with income.

The Oklahoma Plan incorporated some key principles, the first of which was to incorporate public health approaches. Oklahoma is at the bottom when it comes to health outcomes as a state. The Oklahoma Plan wants to try to address those and move that to get us off the bottom rung to get us to exhibit a more healthy population. It also addresses an individual's accountability for wellness; personal responsibility for behaviors, cost, and the way the individual interfaces with the health insurance industry. It also aligns the plans to reduce the number of uninsured, reduce the reliance on Medicaid and support the state's economic base.

Leavitt recommended that we utilize the Insure Oklahoma framework to provide the care for the uninsured. Leavitt came on site on multiple occasions and heard from many people face-to-face and a multitude of others through written and telephonic communication, and everyone said they liked Insure Oklahoma; they support Insure Oklahoma. If they are going to move forward with anything, it should probably be the Insure Oklahoma vehicle.

Leavitt was positive about Insure Oklahoma and recommended coverage of the program. No decisions have been made yet. Leavitt encourages continuing Insure Oklahoma and recommends the State form a steering committee to fully develop the plan.

The ten year impact - Leavitt did their own financial model of potential cost to the State enrollment, and the potential cost over a ten year period. Over 2014-2023, the cost to the State would be about $850 million to provide the new coverage. Further information on the Leavitt report is on our website at www.okhca.org/leavitt.

A question was asked about the notification requirement process of the Insure Oklahoma program ending. Ms. Heater replied that we know that notices, per our federal requirements to shut down the program, have to be sent at a certain date and time. We are at that point. The notices right now, even though we are negotiating, because there is a chance the program will be expired at the end of this calendar year. We have to proceed with the plan to send out notices at the end of July. We know at this point we have to send out the notices that the program is going to end, and hope we can redact that in the future. We will continue to take applications until the program ends.

A question was asked if a 12 year-old can have Insure Oklahoma. Ms. Heater replied no, for a child that is otherwise qualified for the SoonerCare full benefit in the red or orange categories shown on the slide, we want that child to have the most comprehensive coverage possible. If there is a 12 year-old that is at, for example, 80% of the poverty level, that child is enrolled through SoonerCare and not Insure Oklahoma.

A question was asked if the child was in a family over 185%, and where they would fall. Ms. Heater answered, currently, if there is a child in a family that is earning in the 185%-200% FPL that child is served through Insure Oklahoma.

A comment was made that if we don't do this, the people that need it most, the adults under 100% of FPL are not going to get anything. They don't qualify for the exchange; they don't qualify for Medicaid. The people that are the poorest will not have coverage, and we heard that poverty impacts Oklahoma's outcomes more than anything. It is so illogical not to do this.

Ms. Heater said Leavitt recognized this, and that is why in their recommendation they show the stopgap coverage, to make sure we have something for the people under 100% FPL.

Dr. Crawford said the other impact that is included in the indirect benefit to the State is the loss of the Disproportionate Share Hospital (DSH) payments to the rural hospitals, that may cause closure of rural hospitals around the state, and its economic impact on rural towns. Ms. Heater replied Oklahoma is a relatively low DSH state, and in the federal regulations there has been some extension of when those cuts will actually occur, although it looks like they are not slated to occur until 2015. That is still something we see in the future.

X. Informational Items: Joseph Fairbanks

Mr. Fairbanks discussed the informational items list in the packet. Many of the items are in the very beginning stages of development and there is not a lot of detail on some. This is informational and these items may be seen in the next couple of months.

There were no questions.

XI. New Business

Motion for the MAC to recommend to the Board endorsing the Leavitt Report recommendations part of the report. The MAC members strongly agreed to endorse it. Dr. Rhynes mentioned access issues that come up, i.e., a patient who has diabetes and retinopathy, that the first sign they have diabetes would be that they can't see; we don't want to limit access..

Ms. Case approved. Ms. Davis seconded. All in favor. Motion carried.

The OHCA Annual Board Meeting and Retreat will be held August 21-23, 2013, at the Quartz Mountain Lodge in Lone Wolf, OK. The MAC members are encouraged to attend. Ms. Gibbons will be sending the MAC an invitation via electronic mail.

X. Adjourn

Next Meeting: Thursday, September 19, 2013.

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2013
Submitted to the CEO & Board
August 21, 2013

- Revenues for OHCA through June, accounting for receivables, were **$3,685,696,908** or **(1.8%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,668,549,350 or 2.9% under** budget.
- The state dollar budget variance through June is **$42,966,790 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		39.5
Administration		7.7
Contingent Liability		(11.0)
Revenues:		
Taxes and Fees		(2.9)
Drug Rebate		8.3
Overpayments/Settlements		1.4
Total FY 13 Variance	**$**	**43.0**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
For the Fiscal Year Ended June 30, 2013

REVENUES	FY13 Budget YTD	FY13 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 906,983,007	$ 906,983,007	$ -	0.0%
Federal Funds	2,031,433,211	1,951,972,728	(79,460,483)	(3.9)%
Tobacco Tax Collections	59,803,622	57,728,101	(2,075,521)	(3.5)%
Quality of Care Collections	65,498,717	64,679,143	(819,574)	(1.3)%
Prior Year Carryover	66,575,735	66,575,735	-	0.0%
Federal Deferral - Interest	144,766	144,766	-	0.0%
Contingent Liability	-	(11,000,000)	(11,000,000)	0.0%
Drug Rebates	172,134,268	195,082,200	22,947,932	13.3%
Medical Refunds	48,430,941	52,075,414	3,644,473	7.5%
SHOPP	383,380,761	383,380,761	-	0.0%
Other Revenues	17,866,054	18,075,053	208,999	1.2%
TOTAL REVENUES	**$ 3,752,251,082**	**$ 3,685,696,908**	**$ (66,554,174)**	**(1.8)%**

EXPENDITURES	FY13 Budget YTD	FY13 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 46,927,545**	**$ 42,441,024**	**$ 4,486,521**	**9.6%**
ADMINISTRATION - CONTRACTS	**$ 133,538,768**	**$ 118,437,046**	**$ 15,101,722**	**11.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	34,141,517	33,614,916	526,600	1.5%
Acute Fee for Service Payments:				
Hospital Services	920,206,695	871,207,263	48,999,433	5.3%
Behavioral Health	19,635,474	20,100,557	(465,083)	(2.4)%
Physicians	477,192,649	475,260,089	1,932,561	0.4%
Dentists	148,649,630	145,256,891	3,392,739	2.3%
Other Practitioners	75,375,944	68,910,291	6,465,652	8.6%
Home Health Care	22,432,397	21,263,490	1,168,906	5.2%
Lab & Radiology	59,992,100	59,522,427	469,673	0.8%
Medical Supplies	51,047,838	50,648,863	398,976	0.8%
Ambulatory/Clinics	111,529,115	106,321,133	5,207,982	4.7%
Prescription Drugs	401,294,560	396,194,646	5,099,914	1.3%
OHCA TFC	3,225,077	2,420,685	804,392	0.0%
Other Payments:				
Nursing Facilities	548,637,147	535,973,299	12,663,848	2.3%
ICF-MR Private	58,036,262	58,151,524	(115,262)	(0.2)%
Medicare Buy-In	131,728,088	131,025,519	702,568	0.5%
Transportation	62,676,020	60,673,751	2,002,269	3.2%
MFP-OHCA	1,595,278	1,568,962	26,316	0.0%
EHR-Incentive Payments	38,968,791	38,968,791	-	0.0%
Part D Phase-In Contribution	78,256,064	77,694,210	561,854	0.7%
SHOPP payments	352,893,974	352,893,974	-	0.0%
Total OHCA Medical Programs	**3,597,514,619**	**3,507,671,280**	**89,843,339**	**2.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,778,070,314**	**$ 3,668,549,350**	**$ 109,520,964**	**2.9%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (25,819,232)**	**$ 17,147,558**	**$ 42,966,790**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
For the Fiscal Year Ended June 30, 2013

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 34,068,753	$ 33,595,682	$ -	$ 453,837	$ -	$ 19,235	$ -
Inpatient Acute Care	747,350,743	545,615,673	486,687	9,985,733	51,724,464	2,066,221	137,471,965
Outpatient Acute Care	278,802,215	263,433,838	41,604	10,487,997	-	4,838,776	-
Behavioral Health - Inpatient	23,805,769	12,403,158	-	637,431	-		10,765,179
Behavioral Health - Psychiatrist	7,697,398	7,697,398	-	-	-	-	-
Behavioral Health - Outpatient	21,991,697	-	-	-	-	-	21,991,697
Behavioral Health Facility- Rehab	279,337,419	-	-	-	-	99,458	279,337,419
Behavioral Health - Case Management	8,157,277	-	-	-	-	-	8,157,277
Behavioral Health - PRTF	98,945,793	-	-	-	-	-	98,945,793
Residential Behavioral Management	19,330,239	-	-	-	-	-	19,330,239
Targeted Case Management	69,776,470	-	-	-	-	-	69,776,470
Therapeutic Foster Care	2,420,685	2,420,685	-	-	-	-	-
Physicians	529,917,964	405,212,266	58,101	14,043,328	63,282,105	6,707,618	40,614,548
Dentists	145,340,702	137,133,043	-	83,811	8,075,106	48,742	-
Mid Level Practitioners	3,890,770	3,794,676	-	91,215	-	4,880	-
Other Practitioners	65,373,269	63,632,878	446,364	262,533	1,016,493	15,001	-
Home Health Care	21,263,525	21,240,612	-	35	-	22,878	-
Lab & Radiology	62,977,747	58,755,615	-	3,455,321	-	766,812	-
Medical Supplies	51,429,126	48,005,691	2,582,415	780,264	-	60,757	-
Clinic Services	110,953,733	96,070,821	-	1,498,766	-	270,743	13,113,403
Ambulatory Surgery Centers	10,448,374	9,953,816	-	468,805	-	25,753	-
Personal Care Services	12,543,813	-	-	-	-	-	12,543,813
Nursing Facilities	535,973,299	320,183,243	175,152,041	-	40,620,312	17,702	-
Transportation	60,392,297	54,624,111	2,564,264	-	3,144,992	58,930	-
GME/IME/DME	126,057,898	-	-	-	-	-	126,057,898
ICF/MR Private	58,151,524	47,298,309	10,023,001	-	830,214	-	-
ICF/MR Public	53,223,008	-	-	-	-	-	53,223,008
CMS Payments	208,719,729	206,896,874	1,822,855	-	-	-	
Prescription Drugs	416,190,550	348,780,378	-	19,995,903	45,728,022	1,686,247	-
Miscellaneous Medical Payments	282,981	276,465	-	1,527	-	4,989	-
Home and Community Based Waiver	163,083,612	-	-	-	-	-	163,083,612
Homeward Bound Waiver	87,888,659	-	-	-	-	-	87,888,659
Money Follows the Person	3,507,431	1,568,962	-	-	-	-	1,938,469
In-Home Support Waiver	22,902,226	-	-	-	-	-	22,902,226
ADvantage Waiver	177,994,016	-	-	-	-	-	177,994,016
Family Planning/Family Planning Waiver	11,236,581	-	-	-	-	-	11,236,581
Premium Assistance*	51,290,007	-	-	51,290,007		-	-
EHR Incentive Payments	38,968,791	38,968,791	-	-	-	-	-
SHOPP Payments**	352,893,974	352,893,974	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,974,580,067**	**$2,727,562,984**	**$ 193,177,331**	**$ 113,536,514**	**$ 214,421,708**	**$ 16,714,742**	**$1,356,372,273**

* Includes $50,917,023.11 paid out of Fund 245 and **$352,893,974.23 paid out of Fund 205

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
For the Fiscal Year Ended June 30, 2013

		FY13 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	539,306,924
Federal Funds		870,974,463
TOTAL REVENUES	**$**	**1,410,281,387**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	163,083,612
Money Follows the Person		1,938,469
Homeward Bound Waiver		87,888,659
In-Home Support Waivers		22,902,226
ADvantage Waiver		177,994,016
ICF/MR Public		53,223,008
Personal Care		12,543,813
Residential Behavioral Management		15,335,389
Targeted Case Management		51,064,018
Total Department of Human Services		**585,973,210**
State Employees Physician Payment		
Physician Payments		40,614,548
Total State Employees Physician Payment		**40,614,548**
Education Payments		
Graduate Medical Education		74,644,444
Graduate Medical Education - PMTC		4,737,374
Indirect Medical Education		30,449,271
Direct Medical Education		16,226,809
Total Education Payments		**126,057,898**
Office of Juvenile Affairs		
Targeted Case Management		3,257,907
Residential Behavioral Management		3,994,851
Total Office of Juvenile Affairs		**7,252,758**
Department of Mental Health		
Case Management		8,157,277
Inpatient Psych FS		10,765,179
Outpatient		21,991,697
PRTF		98,945,793
Rehab		279,337,419
Total Department of Mental Health		**419,197,366**
State Department of Health		
Children's First		2,186,665
Sooner Start		2,006,096
Early Intervention		6,186,283
EPSDT Clinic		2,315,534
Family Planning		52,160
Family Planning Waiver		11,161,937
Maternity Clinic		46,591
Total Department of Health		**23,955,267**
County Health Departments		
EPSDT Clinic		775,781
Family Planning Waiver		22,484
Total County Health Departments		**798,264**
State Department of Education		**108,228**
Public Schools		**6,973,368**
Medicare DRG Limit		**128,438,192**
Native American Tribal Agreements		**7,969,401**
Department of Corrections		**1,327,949**
JD McCarty		**7,705,824**
Total OSA Medicaid Programs	**$**	**1,356,372,273**
OSA Non-Medicaid Programs	**$**	**74,326,441**
Accounts Receivable from OSA	**$**	**20,417,326**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

For the Fiscal Year Ended June 30, 2013

REVENUES		FY 14 Revenue
SHOPP Assessment Fee	$	157,690,738
Federal Draws		225,468,462
Interest		104,146
Penalties		97,375
State Appropriations		(30,200,000)
TOTAL REVENUES	$	353,160,720

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 13 Expenditures
Program Costs:	**7/1/12 - 9/30/12**	**10/1/12 - 12/31/12**	**1/1/13 - 3/31/13**	**4/1/13 - 6/30/13**		
Hospital - Inpatient Care	76,857,805	76,538,280	81,236,442	81,619,666	**$**	**316,252,193**
Hospital -Outpatient Care	3,224,900	3,217,022	2,815,812	2,825,630	**$**	**12,083,364**
Psychiatric Facilities-Inpatient	5,660,381	5,636,765	6,128,236	6,172,441	**$**	**23,597,823**
Rehabilitation Facilities-Inpatient	217,066	216,157	263,146	264,225	**$**	**960,594**
Total OHCA Program Costs	**85,960,153**	**85,608,224**	**90,443,636**	**90,881,961**	**$**	**352,893,974**
Total Expenditures					**$**	**352,893,974**
CASH BALANCE					**$**	**266,746**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
For the Fiscal Year Ended June 30, 2013

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 64,642,342	$ 64,642,342
Interest Earned	36,801	36,801
TOTAL REVENUES	**$ 64,679,143**	**$ 64,679,143**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 171,362,248	$ 61,741,818	
Eyeglasses and Dentures	286,573	103,252	
Personal Allowance Increase	3,503,220	1,262,210	
Coverage for DME and supplies	2,582,415	930,444	
Coverage of QMB's	1,032,756	372,102	
Part D Phase-In	1,822,855	1,822,855	
ICF/MR Rate Adjustment	4,981,010	1,794,658	
Acute/MR Adjustments	5,041,991	1,816,629	
NET - Soonerride	2,564,264	923,904	
Total Program Costs	**$ 193,177,331**	**$ 70,767,873**	**$ 70,767,873**
Administration			
OHCA Administration Costs	$ 464,427	$ 232,214	
DHS - QOC Exp	80,353	80,353	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	4,500	2,250	
Total Administration Costs	**$ 549,280**	**$ 314,817**	**$ 314,817**
Total Quality of Care Fee Costs	**$ 193,726,611**	**$ 71,082,689**	
TOTAL STATE SHARE OF COSTS			**$ 71,082,689**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
For the Fiscal Year Ended June 30, 2013

REVENUES	FY 12 Carryover	FY 13 Revenue	Total Revenue
Prior Year Balance	$ 27,390,790	$ -	$ 19,860,226
State Appropriations			$ (23,500,000)
Tobacco Tax Collections	-	47,479,153	47,479,153
Interest Income	-	625,826	625,826
Federal Draws	684,936	34,577,769	34,577,769
All Kids Act	(6,983,504)	299,017	299,017
TOTAL REVENUES	$ 21,092,222	$ 82,981,765	$ 79,042,975

EXPENDITURES		FY 12 Expenditures	FY 13 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 50,264,560	$ 50,264,560
	College Students		372,984	372,984
	All Kids Act		652,463	652,463
Individual Plan				
	SoonerCare Choice		$ 436,731	$ 157,354
	Inpatient Hospital		9,896,086	3,565,560
	Outpatient Hospital		10,322,409	3,719,164
	BH - Inpatient Services-DRG		598,391	215,600
	BH -Psychiatrist		-	-
	Physicians		13,898,975	5,007,801
	Dentists		59,050	21,276
	Mid Level Practitioner		89,515	32,252
	Other Practitioners		256,081	92,266
	Home Health		35	13
	Lab and Radiology		3,408,559	1,228,104
	Medical Supplies		762,290	274,653
	Clinic Services		1,473,405	530,868
	Ambulatory Surgery Center		464,522	167,367
	Prescription Drugs		19,688,568	7,093,791
	Miscellaneous Medical		1,527	1,527
	Premiums Collected		-	(2,233,747)
Total Individual Plan			$ 61,356,145	$ 19,873,849
	College Students-Service Costs		$ 712,915	$ 256,863
	All Kids Act- Service Costs		$ 177,446	$ 63,934
Total OHCA Program Costs			$ 113,536,514	$ 71,484,654
Administrative Costs				
	Salaries	$ 30,032	$ 1,594,354	$ 1,624,386
	Operating Costs	48,746	482,858	531,605
	Health Dept-Postponing	-	-	-
	Contract - HP	1,153,217	1,837,806	2,991,023
Total Administrative Costs		$ 1,231,995	$ 3,915,018	$ 5,147,013
Total Expenditures				$ 76,631,667
NET CASH BALANCE		$ 19,860,226		$ 2,411,308

*State Appropriations include $20,000,000 from SFY 2012 and $3,500,000 from SFY 2013

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

For the Fiscal Year Ended June 30, 2013

REVENUES	FY 13 Revenue	State Share
Tobacco Tax Collections	$ 947,610	$ 947,610
TOTAL REVENUES	**$ 947,610**	**$ 947,610**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 19,235	$ 4,851	
Inpatient Hospital	2,066,221	521,101	
Outpatient Hospital	4,838,776	1,220,339	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	17,702	4,465	
Physicians	6,707,618	1,691,661	
Dentists	48,742	12,293	
Mid-level Practitioner	4,880	1,231	
Other Practitioners	15,001	3,783	
Home Health	22,878	5,770	
Lab & Radiology	766,812	193,390	
Medical Supplies	60,757	15,323	
Clinic Services	270,743	68,281	
Ambulatory Surgery Center	25,753	6,495	
Prescription Drugs	1,686,247	425,271	
Transportation	58,930	14,862	
Miscellaneous Medical	4,989	1,258	
Total OHCA Program Costs	$ 16,615,284	$ 4,190,375	
OSA DMHSAS Rehab	$ 99,458	$ 25,083	
Total Medicaid Program Costs	$ 16,714,742	$ 4,215,458	
TOTAL STATE SHARE OF COSTS			**$ 4,215,458**

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

OKLAHOMA HEALTH CARE AUTHORITY

FY-14 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	FY-13	FY-14	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice	30,841,517	35,044,628	4,203,111	13.6%
Hospitals	920,206,695	903,095,305	(17,111,390)	-1.9%
Behavioral Health	22,860,551	23,662,199	801,648	3.5%
Nursing Homes	548,637,147	583,765,542	35,128,395	6.4%
Physicians	480,821,412	516,093,311	35,271,899	7.3%
Dentists	148,649,630	150,572,592	1,922,962	1.3%
Mid-Level Practitioner	4,548,325	4,045,986	(502,339)	-11.0%
Other Practitioners	70,827,619	72,185,096	1,357,477	1.9%
Home Health	22,432,397	22,091,488	(340,909)	-1.5%
Lab & Radiology	59,992,100	68,112,154	8,120,054	13.5%
Medical Supplies	51,047,838	53,612,794	2,564,956	5.0%
Clinic Services	100,738,982	108,361,133	7,622,151	7.6%
Ambulatory Surgery Center	10,790,133	10,416,482	(373,651)	-3.5%
Prescription Drugs	401,294,560	414,682,775	13,388,215	3.3%
Miscellaneous	386,558	317,855	(68,703)	-17.8%
ICF-MR Private	58,036,262	59,778,856	1,742,594	3.0%
Transportation	62,289,462	63,306,454	1,016,992	1.6%
Medicare Buy-in	131,728,088	136,396,322	4,668,234	3.5%
Medicare clawback payment	78,256,064	76,064,816	(2,191,248)	-2.8%
SHOPP - Supplemental Hosp Offset Pymt.	353,920,305	361,774,545	7,854,240	2.2%
Money Follows the Person - Enhanced	1,595,278	1,623,149	27,871	1.7%
Electronic Health Records Incentive Pymts	72,702,373	39,788,361	(32,914,012)	-45.3%
HAN - Health Access Network	3,300,000	3,300,000	-	0.0%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,635,992,678	3,708,181,223	72,188,545	2.0%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	55,576,497	51,954,038	(3,622,459)	-6.5%
Individual Plan - IP	65,651,723	63,857,987	(1,793,736)	-2.7%
TOTAL INSURE OKLAHOMA PROGRAM	121,228,220	115,812,025	(5,416,195)	-4.5%
OHCA Administration				
Operations	42,428,024	53,609,151	11,181,127	26.4%
Contracts	57,573,091	54,136,699	(3,436,393)	-6.0%
Insure Oklahoma Admin	3,711,407	3,497,604	(213,803)	-5.8%
Information Services	90,579,586	75,634,130	(14,945,456)	-16.5%
Grant Mgmt	2,935,236	2,986,598	51,362	1.7%
TOTAL OHCA ADMIN	197,227,344	189,864,182	(7,363,162)	-3.7%
TOTAL OHCA PROGRAMS	**3,954,448,242**	**4,013,857,430**	**59,409,188**	**1.5%**
Other State Agency (OSA) Programs				
Department of Human Services (OKDHS)	591,329,552	614,759,006	23,429,454	4.0%
Oklahoma State Dept of Health (OSDH)	21,699,075	25,535,786	3,836,711	17.7%
The Office of Juvenile Affairs (OJA)	8,043,174	7,678,500	(364,674)	-4.5%
University Hospitals	300,421,992	282,685,856	(17,736,136)	-5.9%
Physician Manpower Training Commission	5,529,093	5,604,093	75,000	1.4%
Department of Mental Health (DMHSAS)	354,746,873	406,883,941	52,137,068	14.7%
Department of Education (DOE)	7,101,970	6,971,096	(130,874)	-1.8%
OSU Supplemental / DRG	9,000,000	9,000,000	-	0.0%
Non-Indian Payments	6,398,470	9,348,459	2,949,989	46.1%
Department of Corrections (DOC)	723,501	1,144,923	421,422	58.2%
JD McCarty	6,496,210	7,124,594	628,384	0.0%
OSA Non-Title XIX	101,659,710	101,659,710	-	0.0%
TOTAL OSA PROGRAMS	**1,413,149,620**	**1,478,395,964**	**65,246,344**	**4.6%**
TOTAL MEDICAID PROGRAM	**5,367,597,862**	**5,492,253,393**	**124,655,531**	**2.3%**

OKLAHOMA HEALTH CARE AUTHORITY

FY-14 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	FY-13	FY-14	Inc / (Dec)	% Change
REVENUES				
Federal - program	3,111,801,686	3,195,359,462	83,557,776	2.7%
Federal - admin	132,481,774	122,530,736	(9,951,038)	-7.5%
Drug Rebates	172,134,268	176,208,819	4,074,551	2.4%
Medical Refunds	48,430,941	48,559,263	128,322	0.3%
NF Quality of Care Fee	66,096,907	81,359,250	15,262,343	23.1%
OSA Refunds & Reimbursements	591,918,466	614,767,733	22,849,267	3.9%
Tobacco Tax	103,462,057	96,941,823	(6,520,234)	-6.3%
Insurance Premiums	7,178,501	7,144,639	(33,862)	-0.5%
Misc Revenue	84,000	84,000	-	0.0%
Prior Year Carryover	43,075,735	32,616,512	(10,459,223)	-24.3%
Other Grants	2,736,058	2,595,314	(140,744)	-5.1%
Hospital Provider Fee (SHOPP bill)	157,714,462	160,384,570	2,670,108	1.7%
Insure Oklahoma Fund 245 - Transfer	23,500,000	3,000,000	(20,500,000)	-87.2%
State Appropriated	906,983,007	950,701,274	43,718,267	4.8%
TOTAL REVENUES	**5,367,597,862**	**5,492,253,394**	**124,655,532**	**2.3%**

SoonerCare Programs

June 2013 Data for August 2013 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2012	Enrollment June 2013	Total Expenditures June 2013	Average Dollars Per Member Per Month June 2013
SoonerCare Choice Patient-Centered Medical Home			468,268	**539,670**	**$132,783,916**	
	Lower Cost	*(Children/Parents; Other)*		493,263	$94,014,320	$191
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		46,407	$38,769,596	$835
SoonerCare Traditional			241,278	**194,294**	**$170,056,407**	
	Lower Cost	*(Children/Parents; Other)*		86,780	$37,905,100	$437
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,514	$132,151,306	$1,229
SoonerPlan			41,378	**50,556**	**$643,377**	$13
Insure Oklahoma			31,502	**29,860**	**$8,933,895**	
	Employer-Sponsored Insurance		17,728	16,502	$4,093,732	$248
	Individual Plan		13,773	13,358	$4,840,164	$362
TOTAL			**782,425**	**814,380**	**$312,417,595**	

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 $73,221,348 are excluded.

Net Enrollee Count Change from Previous Month Total	2,982

New Enrollees	17,748

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,646
Aged/Blind/Disabled	*Adult*	133,403
Other	*Child*	138
Other	*Adult*	21,074
PACE	*Adult*	124
TEFRA	*Child*	477
Living Choice	*Adult*	104
OLL Enrollment		**174,966**

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

Medicare and SoonerCare	Monthly Average SFY2012	Enrolled June 2013
Dual Enrollees	**107,504**	**108,648**

		Monthly Average SFY2012	Enrolled June 2013
Long-Term Care Members		**15,770**	**15,480**
	Child	87	55
	Adult	15,683	15,425

FACILITY PER MEMBER PER MONTH

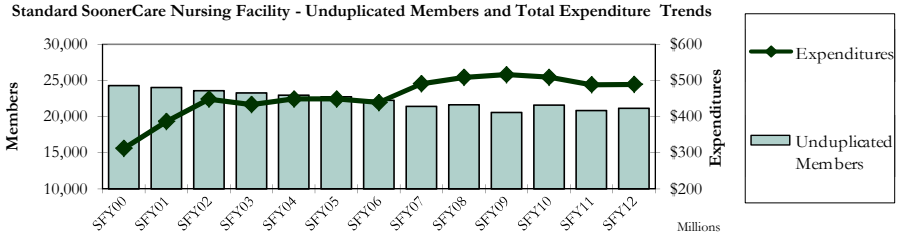
$3,462

SFY2012 Long-Term Care

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

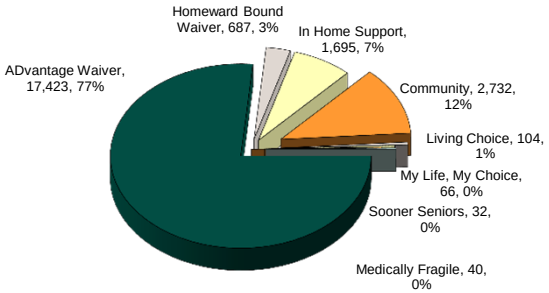
Data as of September 2012

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 SFY2012	Enrolled June 2013*
Total Providers		**29,723**	**38,486**
	In-State	20,881	30,259
	Out-of-State	8,842	8,227

*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 SFY2012	*Enrolled June 2013**	Monthly Average SFY2012	Enrolled June 2013
Physician***	*7,497*	*8,024*	*13,790*	12,456
Pharmacy	*874*	*915*	*1,153*	1,234
Mental Health Provider**	*3,395*	*6,635*	*3,449*	6,707
Dentist	*986*	*1,243*	*1,124*	1,432
Hospital	*194*	*184*	*934*	490
Optometrist	*550*	*517*	*587*	541
Extended Care Facility	*375*	*360*	375	360

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

Total Primary Care Providers***	*4,915*	*5,155*	6,955	6,677
Patient-Centered Medical Home	*1,711*	*2,031*	1,739	2,111

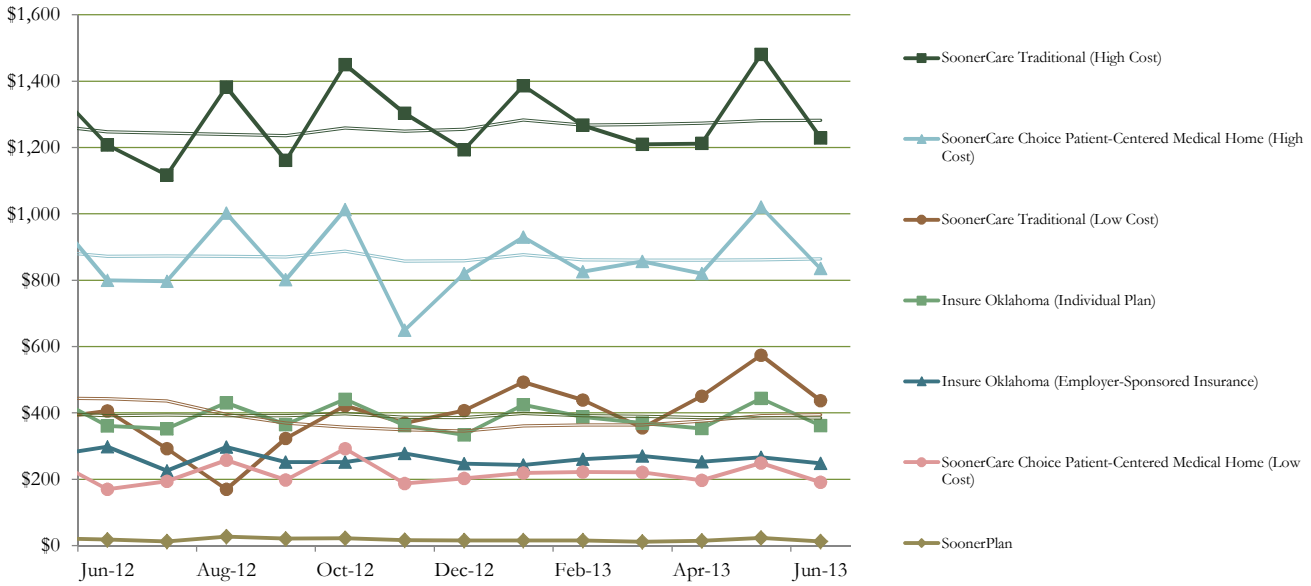
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

**Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement OHCA is directly contracting with providers that had previously billed through a group or agency. This contributed to the increase in the provider counts for Mental Health Providers.

***Decrease in current month's count is due to contract renewal period which is typical during all renewal periods.

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 8/5/2013	July 2013		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	35	$641,750	1,745	$39,801,251
Eligible Hospitals	0*	$0	90	$78,573,319
Totals	35	$641,750	1,835	$118,374,570

*Current Eligible Hospitals Paid

SUMMARY

WORKFOLDER 13-08; Systems Simplification Implementation

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.

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.

Summary

13-16 Insure Oklahoma— Insure Oklahoma (IO) rules are revised to align with the Special Terms and Conditions of the Section 1115 Demonstration Waiver. In accordance with waiver special terms and conditions, the federal government has approved a one year (calendar) extension of the IO program. Rules are revised to remove Individual Plan children (while retaining Employer Sponsored Insurance (ESI) children) and limit adult Individual Plan enrollment to persons with household income at or below 100 percent of FPL. Revisions also include changes to the Individual Plan copayment structure; copayments cannot exceed current federal maximums with the exception of emergency room (ER) visits in which case the existing copay for ER visits will remain at $30.00.

Budget Impact: Budget Neutral

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 3. INSURE OKLAHOMA IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma IP adult benefits

(a) All IP adult benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in 317:45-11-11.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services~~,~~ and limits~~, and applicable co-payments~~ are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. ~~Dependent children coverage is found at 317:45-11-12. Children are not held to the maximum lifetime benefit.~~ Member cost sharing related to premium and co-payments cannot exceed federal maximums with the exception of emergency room visits, in which case the State establishes the maximum for member cost share. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage for IP services includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in

accordance with 317:30-5-22(b)(2). PCP referral is required. ~~Standard radiology (X-ray or Ultrasound): $0 co-pay.; Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.~~

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.

(6) Inpatient Hospital Benefits. Covered in accordance with 317:30-5-41, 317:30-5-47 and 317:30-5-95~~; $50 co-pay per admission~~.

(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year~~ with a $10 co-pay~~. This visit counts as an office visit.

(8) Office Visits/Specialist Visits. Covered in accordance with 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits~~; $10 co-pay per visit~~.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures~~; $25 co-pay per visit~~.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections~~; $10 co-pay per visit~~.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year~~; $10 co-pay per visit~~.

(10) Maternity (Obstetric). Covered in accordance with 317:30-5-22. ~~Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.~~

(11) Laboratory/Pathology. Covered in accordance with 317:30-5-20~~; $0 co-pay~~.

(12) Mammogram (Radiological or Digital). Covered in accordance with 317:30-5-901~~; $0 co-pay~~.

(13) Immunizations. Covered in accordance with 317:30-5-2.

(14) Assistant Surgeon. Covered in accordance with 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility~~; $0 co-pay~~.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts~~; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies~~.

(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with 317:30-5-95.1~~; $50 co-pay per admission~~.

(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient). Outpatient benefits are limited to 48 visits per calendar year. Additional visits may be approved as medically necessary.

(A) Agency services. Covered in accordance with 317:30-5-241 and 317:30-5-596~~; $10 co-pay per visit~~.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in 317:30-5-2.

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under 59 Okla. Stat. '1353(4) and (5), 59 '1903(C) and (D), 59 '1925.3(B) and (C), and 59 '1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are

limited to 8 therapy services per month per member and 8 testing units per year per member~~; $10 co-pay per visit~~.

(19) Durable Medical Equipment and Supplies. Covered in accordance with 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy~~; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment~~.

(20) Diabetic Supplies. Covered in accordance with 317:30-5-211.15; not subject to $15,000 annual DME limit~~; $5 co-pay per prescription~~.

(21) Oxygen. Covered in accordance with 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit~~; $5 co-pay per month~~.

(22) Pharmacy. Covered in accordance with 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits~~; $5/$10 co-pay per prescription~~.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with 317:30-5-72.1~~; $5/$10 co-pay per product~~.

(24) Nutrition Services. Covered in accordance with 317:30-5-1076~~; $10 co-pay per visit~~.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with 317:30-5-211.13~~; $25 co-pay per prosthesis~~.

(26) Surgery. Covered in accordance with 317:30-5-8~~; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit~~.

(27) Home Dialysis. Covered in accordance with 317:30-5-211.13; not subject to $15,000 annual DME limit~~; $0 co-pay~~.

(28) Parenteral Therapy. Covered in accordance with 317:30-5-211.14; not subject to $15,000 annual DME limit~~; $25 co-pay per month~~.

(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with 317:30-3-57~~; $0 co-pay~~.

(30) Home Health and Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with 317:30-5-211.15 and 317:30-5-42.16(b)(3).

(31) Fundus photography.

(32) Perinatal dental care for pregnant women. Covered in accordance with 317:30-5-696~~; $0 co-pay~~.

317:45-11-11. Insure Oklahoma IP non-covered services

Certain health care services are not covered in the Insure Oklahoma IP adult benefit package listed in 317:45-11-10. These services include, but are not limited to:

(1) services not considered medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;

(3) organ and tissue transplant services;

(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;

(5) procedures, services and supplies related to sex transformation;

(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;

(7) cosmetic surgery, except as medically necessary and as covered in 317:30-3-59(19);

(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;

(9) experimental procedures, drugs or treatments;

(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in 317:30-5-696;

(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;

(12) physical medicine including chiropractic and acupuncture therapy;

(13) hearing services;

(14) transportation [emergency or non-emergency (air or ground)];

~~(15) rehabilitation (inpatient);~~

~~(16) cardiac rehabilitation;~~

~~(17)~~(15) allergy testing and treatment;

~~(18) home health care with the exception of medications, intravenous (IV) therapy, supplies;~~

~~(19)~~(16) hospice regardless of location;

~~(20)~~(17) Temporomandibular Joint Dysfunction (TMD) (TMJ);

~~(21)~~(18) genetic counseling;

~~(22)~~(19) fertility evaluation/treatment/and services;

~~(23)~~(20) sterilization reversal;

~~(24)~~(21) Christian Science Nurse;

~~(25)~~(22) Christian Science Practitioner;
~~(26)~~(23) skilled nursing facility;
~~(27)~~(24) long-term care;
~~(28)~~(25) stand by services;
~~(29)~~(26) thermograms;
~~(30)~~(27) abortions (for exceptions, refer to 317:30-5-6);
~~(31)~~(28) services of a Lactation Consultant;
~~(32)~~(29) services of a Maternal and Infant Health Licensed Clinical Social Worker;
~~(33)~~(30) enhanced services for medically high risk pregnancies as found in 317:30-5-22.1;
~~(34)~~(31) ultraviolet treatment-actinotherapy; and
~~(35)~~(32) private duty nursing.

317:45-11-12. Insure Oklahoma IP children benefits [REVOKED]

~~(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in 317:30-3- 1 (f) . The scope of IP child benefits described in this Section is subject to specific non-covered services listed in 317:45- 11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Native American children providing documentation of ethnicity are exempt from co-payments.~~

~~Coverage includes:~~

~~(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.~~

~~(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.~~

~~(3) Chelation therapy. Covered for heavy metal poisoning only.~~

~~(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.~~

~~(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.~~

~~(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, two replacement batteries per year - 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.~~

~~(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.~~
~~(8) Dialysis. Covered as medically necessary.~~
~~(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.~~
~~(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.~~
~~(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.~~
~~(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.~~
~~(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.~~
~~(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.~~
~~(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.~~
~~(16) Laboratory services. Covered as medically necessary.~~
~~(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior authorization required issued in four unit increments-not to exceed eight units/hours per testing set; $0 co-pay.~~
~~(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.~~
~~(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.~~
~~(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.~~
~~(21) Nutrition services. Covered as medically necessary; $10 co-pay.~~
~~(22) Nutritional support. Covered as medically necessary; not~~

~~included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.~~
~~(23) Other medically necessary services. Covered as medically necessary.~~
~~(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.~~
~~(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies or opportunistic infections; $25 co-pay per visit; $10 co-pay per visit for therapeutic radiology or chemotherapy.~~
~~(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.~~
~~(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.~~
~~(28) Physical, occupational, and speech therapy. Covered as medically necessary. $10 co-pay per visit.~~
~~(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.~~
~~(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.~~
~~(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.~~
~~(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.~~
~~(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.~~
~~(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.~~
~~(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.~~
~~(36) Ultraviolet treatment-actinotherapy. Covered as~~

~~medically necessary; prior authorization required after one visit per 365 sequential days; $5 co-pay.~~

~~(b) A PCP referral is required to see any other provider with the exception of the following services:~~

~~(1) behavioral health services;~~

~~(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;~~

~~(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;~~

~~(4) women's routine and preventive health care services;~~

~~(5) emergency medical condition as defined in 317:30-3-1; and~~

~~(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.~~

317:45-11-13. Insure Oklahoma IP children non-covered services [REVOKED]

~~Certain health care services are not covered in the Insure Oklahoma IP benefit package for children listed in 317:45-11-12. These services include, but are not limited to:~~

~~(1) services not considered medically necessary;~~

~~(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;~~

~~(3) organ and tissue transplant services;~~

~~(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;~~

~~(5) procedures, services and supplies related to sex transformation;~~

~~(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;~~

~~(7) cosmetic surgery, except as medically necessary and as covered in 317:30-3-59(19);~~

~~(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;~~

~~(9) experimental procedures, drugs or treatments;~~

~~(10) transportation [non-emergency (air or ground)];~~

~~(11) rehabilitation (inpatient);~~

~~(12) cardiac rehabilitation;~~

~~(13) allergy testing and treatment;~~

~~(14) Temporomandibular Joint Dysfunction (TMD) (TMJ);~~
~~(15) genetic counseling;~~
~~(16) fertility evaluation/treatment/and services;~~
~~(17) sterilization reversal;~~
~~(18) Christian Science Nurse;~~
~~(19) Christian Science Practitioner;~~
~~(20) skilled nursing facility;~~
~~(21) long-term care;~~
~~(22) stand by services;~~
~~(23) thermograms;~~
~~(24) abortions (for exceptions, refer to 317:30-5-6);~~
~~(25) donor transplant expenses;~~
~~(26) tubal ligations and vasectomies; and~~
~~(27) private duty nursing.~~

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma IP eligibility requirements

(a) Working adults not eligible to participate in an employer's qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.

(b) The eligibility determination will be processed within 30 days from the date the complete application is received. The applicant will be notified in writing of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in 317:45-11-22, at the time they make application;

(2) be a US citizen or alien as described in 317:35-5-25;

(3) be an Oklahoma resident;

(4) provide social security numbers for all household members;

(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;

(6) be age 19 through 64 or an emancipated minor;

(7) make premium payments by the due date on the invoice;

(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a) (1)-(2);

(9) be not currently covered by a private health insurance policy or plan; and

(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~

(2) be ineligible for participation in their employer's qualified health plan due to number of hours worked.

(3) have received notification from Insure Oklahoma indicating their employer has applied for Insure Oklahoma and has been approved.

(e) If employed and working for an employer who does not offer a qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~ 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.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~ No standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work may be made for self-employed individuals. Allowable Deductions for work related expenses for self-employed individuals, with the exception of the standard deduction, are found at 317:35-10-26(b)(1);

(2) verify self-employment and income by providing the most

recent federal tax return with all supporting schedules and copies of all 1099 forms; and

(3) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:

(1) Applicant must have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~ In determining income, 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, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) OESC eligibility letter,

(B) OESC weekly unemployment payment statement, or

(C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and:

(1) Applicant must have an annual gross household income at or below ~~250~~100 percent of the Federal Poverty Level based on a family size of one. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~

(2) Applicant must verify eligibility by providing a copy of their:

(A) ticket to work, or

(B) ticket to work offer letter.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 30 calendar days of the change.

317:45-11-21. Dependent eligibility

(a) If the spouse of an Insure Oklahoma IP approved individual is eligible for Insure Oklahoma ESI, they must apply for Insure Oklahoma ESI. Spouses cannot obtain Insure Oklahoma IP coverage

if they are eligible for Insure Oklahoma ESI.
(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in 317:45-11-20 (a) through (g) to be eligible for Insure Oklahoma IP.
(c) The dependent of an applicant approved according to the guidelines listed in 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma IP.
(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma IP, then the associated dependent enrolled under that applicant is also ineligible.
(e) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA). College students must also provide a copy of their current student schedule to prove full-time student status.
~~(f) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.~~
~~(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.~~
~~(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.~~
~~(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:~~
~~(A) the cost of covering the family under the ESI plan meets or exceeds 10 percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;~~
~~(B) loss of employment by a parent which made coverage available;~~
~~(C) affordable ESI is not available; "affordable" coverage~~

~~is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or~~

~~(D) loss of medical benefits under SoonerCare.~~

(g) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 30 calendar days of the change.

317:45-11-21.1. Certification of newborn child deemed eligible [REVOKED]

~~(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma IP and the annual gross household income does not exceed SoonerCare requirements. The newborn child is deemed eligible through the last day of the month the child attains the age of one year.~~

~~(b) The newborn child's eligibility is not dependent on the mother's continued eligibility in Insure Oklahoma IP. The child's eligibility is based on the original eligibility determination of the mother for Insure Oklahoma IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.~~

~~(c) The newborn child's certification period is shortened only in the event the child:~~

~~(1) loses Oklahoma residence; or~~

~~(2) expires.~~

~~(d) No other conditions of eligibility are applicable, including social security number enumeration and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.~~

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their monthly gross household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed four percent of their monthly gross household income, based on a family size

of one and capped at ~~250~~100 percent of the Federal Poverty Level. ~~The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.~~

(3) Native Americans providing documentation of ethnicity are exempt from premium payments.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of Insufficient/Non-sufficient funds.

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. Dental services requirements and benefits [REVOKED]

~~The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Dental coverage is obtained through direct purchase from the OHCA. The existing cost sharing requirements for IP qualified children apply. Native Americans children providing documentation of their ethnicity are exempt from dental co-pay requirements. Children obtaining medical coverage through IP receive Dental IP coverage. The OHCA contracts with Dental IP providers utilizing the SoonerCare network. The Dental IP providers are reimbursed pursuant to the SoonerCare fee schedule for rendered services.~~

~~(1) The Dental IP program is covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage is provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Prior authorization is required for certain services.~~

~~(2) Class A services are covered as medically necessary and include preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay is required.~~

~~(3) Class B services are covered as medically necessary and include basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay is required.~~

~~(4) Class C services are covered as medically necessary and include major, prosthodontics care such as crowns, bridges~~

~~and dentures, $25 co-pay is required.~~
~~(5) Class D services are covered as medically necessary and include orthodontic care. Orthodontic care is not covered for cosmetic purposes or any purposes which are not medical in nature, $25 co-pay is required.~~
~~(6) Emergency dental services are covered as medically necessary, no co-pay is required.~~