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POLICY TRANSMITTAL NO. 05-36	DATE: AUGUST 10, 2005
FAMILY SUPPORT SERVICES DIVISION/OKLAHOMA HEALTH CARE AUTHORITY	DEPARTMENT OF HUMAN SERVICES OFFICE OF PLANNING, POLICY & RESEARCH

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-240; 30-5-241; 30-5-243; 30-5-247; 30-5-248 and 35-5-41.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Outpatient Behavioral Health Services rules are revised to: (a) better describe appropriate Alcohol and Other Drug (AOD) treatment services; (b) establish separate service descriptions and allow AOD providers a window to contract without having national accreditation; and (c) add Behavioral Health Aide services to the array of outpatient behavioral health rehabilitation services.

Eligibility rules related to capital resources for individuals related to aged, blind, and disabled are revised to establish criteria for the consideration of annuities purchased after January 31, 2005 when determining their availability to the applicant/recipient.

Original signed on 8-5-05

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Mary Stalnaker, Director  
Family Support Services Division

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Sharon Neuwald, Co-Interim Administrator  
Office of Planning, Policy & Research

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WF # 05-Q (DT)

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**INSTRUCTIONS FOR FILING MANUAL MATERIAL**

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-3611.

**REMOVE**

**INSERT**

317:30-5-240	317:30-5-240, pages 1-8, revised 7-11-05
317:30-5-241	317:30-5-241, pages 1-19, revised 7-11-05
317:30-5-243	-----
317:30-5-247	-----
317:30-5-248	317:30-5-248, 1 page only, revised 7-11-05
317:35-5-41	317:35-5-41, pages 1-33, revised 2-1-05

317:30-5-240. Eligible providers

(a) Definitions. The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

- (1) "AOA" means American Osteopathic Association.
- (2) "AOD" means Alcohol and Other Drug.
- (3) "AODTP" means Alcohol and Other Drug Treatment Professionals.
- (4) "ASAM" means the American Society of Addiction Medicine.
- (5) "ASI" means the Addiction Severity Index.
- (6) "BHRS" means Behavioral Health Rehabilitation Specialist.
- (7) "CARF" means Commission on Accreditation of Rehabilitation Facilities.
- (8) "CMHCs" means Community Mental Health Centers.
- (9) "COA" means Council on Accreditation of Services for Families and Children, Inc.
- (10) "DSM" means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.
- (11) "ICF/MR" means Intermediate Care Facility for the Mentally Retarded.
- (12) "JCAHO" means Joint Commission on Accreditation of Healthcare Organizations.
- (13) "MHP" means Mental Health Professional.
- (14) "OAC" means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.

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OAC 317:30-5-240 p(2)

(15) "ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

(16) "ODMHSAS Contracted Facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse treatment services, and also contract directly with the Oklahoma Healthcare Authority to provide Outpatient Behavioral Health Services.

(17) "OHCA" means Oklahoma Health Care Authority.

(18) "Private Facilities" means those providers that contract directly with the Oklahoma Healthcare Authority to provide Outpatient Behavioral Health Services.

(19) "Public Facilities" means those providers who are regionally based Community Mental Health Centers who are also contract directly with the Oklahoma Healthcare Authority to provide Outpatient Behavioral Health Services.

(20) "RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.

(b) Accredited outpatient organizations. Rehabilitative services are provided by:

(1) Community based outpatient behavioral health organizations, that have a current accreditation status as a provider of behavioral health services, from the CARF, JCAHO, or COA. Providers accredited by CARF/JCAHO/COA must be able to demonstrate that the Scope of the current accreditation includes all programs, services and sites where Medicaid compensated services are rendered. CARF/JCAHO/COA accredited providers will only receive Medicaid reimbursement for services provided under the programs, which are accredited.

(A) Psychiatric Hospitals appropriately licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards including JCAHO accreditation. Psychiatric Hospitals must be able to demonstrate the scope of the current accreditation includes all programs and sites where Medicaid Outpatient Behavioral services will be

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**OAC 317:30-5-240 p(3)**

performed.

(B) Acute Care Hospitals appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA certification. Acute Care Hospitals must be able to demonstrate the scope of the current accreditation includes all programs and sites where Medicaid Outpatient Behavioral Health Services will be performed.

(C) Providers of Alcohol and other Drug Treatment Disorders certified by the designated state certifying agency, the ODMHSAS, on or before December 31, 2005. Providers certified by ODMHSAS must be actively working toward accreditation by one of the three recognized accrediting bodies. Providers in this category must have achieved accreditation from JCAHO, CARF, or COA for the provision of outpatient alcohol and other drug treatment services by January 1, 2007.

(2) Eligible organizations must meet one of the following standards and criteria:

(A) Be an incorporated organization governed by a board of directors; or

(B) A state-operated program under the direction of the ODMHSAS.

(3) Eligible organizations must meet each of the following:

(A) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(B) Have a multi-disciplinary, professional team. This team must include all of the following:

(i) An allopathic or osteopathic Physician licensed in the state in which the service is delivered.

(ii) One of the following licensed mental health professionals:

(I) A Psychologist, Clinical Social Worker, Professional Counselor, Behavioral Practitioner, or

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Marriage and Family Therapist licensed in the state in which the services are delivered, or

(II) An 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, or

(III) An allopathic or osteopathic physician with a current license and board certification in psychiatry in the state in which the service is delivered, or board eligible.

(iii) A Behavioral Health Rehabilitation Specialist as described in subsection (e) of this section, if individual or group rehabilitative services for mental illnesses are provided.

(iv) A Certified Alcohol and Drug Counselor if treatment of alcohol and other drug disorders is provided.

(v) A registered nurse or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support service is provided.

(C) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241. Sites as identified by ODMHSAS as exclusively providing Community-based structured emergency care, or Program for Assertive Community Treatment services are exempted from this requirement.

(i) Mental Health Assessments and/or Alcohol and Drug assessments;

(ii) Individual, Group, and Family Psycho Therapy;

(iii) Individual and Group Rehabilitative services relevant to the population to be served and Alcohol and other Drug Related Services Skill development services if offered by the provider;

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(iv) Mental Health Services Plan done by a non-physician (moderate and low complexity; and

(v) Crisis Intervention services.

(D) Be available 24 hours a day, seven days a week, for Crisis Intervention services.

(E) Provide physician services necessary for the treatment of the behavioral disorders of the population served.

(F) Comply with all applicable Federal and State Regulations.

(G) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, patient grievances, patient rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(H) Demonstrate the ability to keep appropriate records and documentation of services performed.

(I) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(J) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

(4) Provider Specialties.

(A) Public and ODMHSAS Contracted Programs Facilities - Public facilities are the regionally based Community Mental Health Centers and ODMHSAS contracted programs are providers that have a contract with the ODMHSAS to provide Mental Health or Substance Abuse Treatment Services.

(B) Private Programs - Private facilities are those facilities that contract directly with the Oklahoma Healthcare Authority to provide Outpatient Behavioral Health Services.

(c) Provider enrollment and contracting.

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(1) Organizations who have JCAHO, CARF, COA or AOA accreditation will supply the documentation from the accrediting body, along with other information as required for contracting purposes to the OHCA. If the application is approved, a separate provider identification number for each outpatient Behavioral Health Service site will be assigned. The contract must include copies of all required state licenses, accreditation and Medicaid certifications.

(2) Each site operated by an outpatient mental health facility must have a separate provider number. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the patient's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the patient's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) Each MHP, AODTP, BHRS, Nurse, or Physician Assistant performing services for any contracted Outpatient Behavioral Health agency must obtain an individual practitioner identification number. This number is submitted on the claim for each treatment service performed by that practitioner beginning July 1, 2005.

**(d) Mental Health Professional.** Mental Health Professionals (MHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services:

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

(2) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision to become licensed by one of the licensing boards listed in (A) through (E) below. The exemptions from licensure under 59 '1353(4) (Supp. 2000) and (5), 59 '1903(C) and (D) (Supp. 2000), 59 '1925.3(B) (Supp. 2000) and (C), and 59 '1932(C) (Supp. 2000) and (D) do not apply

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to Outpatient Behavioral Health Services.

- (A) Psychology,
- (B) Social Work (clinical specialty only),
- (C) Professional Counselor,
- (D) Marriage and Family Therapist, or
- (E) Behavioral Practitioner.

(3) 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.

**(e) Behavioral Health Rehabilitation Specialist.** The definition of a Behavioral Health Rehabilitation Specialist (BHRS) is as follows:

- (1) Bachelor or master in a mental health related field including, but not limited to, psychology, social work, occupational therapy, family studies; or
- (2) A current license as a registered nurse in Oklahoma; or
- (3) Certification as an Alcohol and Drug Counselor. Allowed to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis; or
- (4) Current certification as a Behavioral Health Case Manager from ODMHSAS and meets OHCA requirements to perform case management services, as described in OAC 317:30-5-585(1).

**(f) Alcohol and other Drug (AOD) Treatment Professionals (AODTP).** Alcohol and other Drug Treatment Professionals are defined as practitioners who are:

- (1) Licensed to practice as an Alcohol and Drug Counselor in the state in which services are provided, or those actively and regularly receiving board approved supervision to become licensed;
- (2) Certified as an Advanced Alcohol and Drug Counselor as

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recognized and approved by an ODMHSAS AOD treatment certifying and/or licensing body;

(3) Certified as an Alcohol and Drug Counselor as recognized by an ODMHSAS recognized and approved AOD treatment certifying and/or licensing body; or

(4) A MHP with a current license to practice who can demonstrate competency in the area of alcohol and drug counseling and treatment.

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**OAC 317:30-5-241 p(1)**

**317:30-5-241. Coverage for adults and children**

(a) **Service descriptions and conditions.** Outpatient behavioral health services are covered for adults and children as set forth in this Section, unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified mental health and/or substance abuse disorder(s). All services are to be for the goal of improvement of functioning, independence, or well being of the client. The client must be able to actively participate in the treatment. Active participation means that the client must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment. The assessment must include a DSM multi axial diagnosis completed for all five axes from the most recent DSM version. All services will be subject to medical necessity criteria. For ODMHSAS Contracted and Private facilities, an agent designated by the Oklahoma Health Care Authority will apply the medical necessity criteria. For public facilities (regionally based CMHCs), the medical necessity criteria will be self-administered following the same required elements as the private and contracted (ODMHSAS) agencies under OAC 317:30-5-241(b)(4)(B)(i). Non prior authorized services will not be Medicaid compensable with the exception of Mental Health Assessment by a Non-Physician, Mental Health Service Plan Development, Crisis Intervention Services (by a MHP and Facility based), and Program of Assertive Community Treatment Services (PACT). Payment is not made for Outpatient Behavioral Health Services for children who are receiving Residential Behavioral Management Services in a Group Home or Therapeutic Foster Care with the exception of Psychotherapy services which must be authorized by the OHCA or its designated agent as medically necessary and indicated, and Crisis Intervention Services (facility based). Residents of nursing facilities are not eligible for Outpatient Behavioral Health services.

(1) **Mental Health Assessment by a Non-Physician** includes a history of psychiatric symptoms, concerns and problems, an evaluation of mental status, a psychosocial and medical history, a full five axes diagnosis and evaluation of current functioning, and an evaluation and assessment of alcohol and other drug use (historic and present). The service must also include an evaluation of the client's strengths and information regarding the client's treatment preferences. For adults, it may include interviews or communications with family, caretakers, or other support persons as permitted by the client.

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For children under the age of 18, it must include an interview with a parent, or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an MHP. The minimum face-to-face time spent in assessment with the client and others as identified previously in this paragraph for a low complexity Mental Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. This service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for AOD providers.

(2) **Alcohol and Drug Assessment.** Alcohol and Drug Assessment includes an assessment of past and present alcohol and other drug use. The ASI is to be completed. This service includes an evaluation of current and past functioning in all major life areas and an evaluation of potential mental illnesses that may also impact treatment. It includes a full five axes diagnosis. The service must also include an evaluation of the client strengths and weaknesses and information regarding the client's treatment preferences. For adults, it may include interviews and/or communication with family, caretakers or other support persons as permitted by the client. For children under the age of 18, it must include an interview with a parent or other adult caretaker. For children, the assessment must also include information on school performance and school based services. This service is performed by an AODTP. The minimum face to face time spent in assessment with the client (and other family or caretakers as previously described in this paragraph) for a low complexity is one and one-half hours. For a moderate complexity it is two hours or more. This service is compensable on behalf of a client who is seeking services for the first time from the contracted agency. The service is not compensable if the client has previously received or is currently receiving services from the agency, unless there has been a gap in services of more than six months and it has been more than one year since the previous assessment. This service is not allowed for Mental Health Providers.

**(3) Mental Health Services Plan Development by a Non-Physician (moderate complexity).** Mental Health Services Plan Development by a Non-Physician (moderate complexity) is to be performed by the practitioners and others who will comprise the treatment team. It is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Mental Health Services Plan is developed based on information obtained in the mental health assessment and includes the evaluation of assessment by the practitioners and the client of all pertinent information. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible MHP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

**(4) Mental Health Services Plan Development by a Non-Physician (low complexity).** Mental Health Services Plan Development by a Non-Physician (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services

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Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Mental Health Services Plan Development by a Non-Physician (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible MHP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

**(5) Alcohol and/or Substance Abuse Services, Treatment Plan Development (moderate complexity).** Alcohol and Substance Abuse Treatment Plan Development (moderate complexity) is to be performed by the AODTP practitioners and others who will comprise the treatment team. The current edition of the ASAM criteria is to be utilized and followed. The service is performed with the direct active participation of the client and a client support person or advocate if requested by the client. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate. The Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the client. The service includes a discharge plan. The service is a process whereby an individualized rehabilitation plan is developed that addresses the client's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited. For adults, it must be focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. For children, the service plan must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. Each type of service to be received must be delineated in the service plan and the practitioner who will be providing and responsible for each service must be identified. In addition, the anticipated frequency of each type of service must be included. This

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service is provided by the client treatment team. This includes all staff responsible for the treatment services delineated in the plan, the client (if over age 14), and the parent/guardian if under age 18. The service plan is not valid until it is signed and dated by the responsible AODTP, the treating physician, the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met. Each signature must have the date written by the signing party on the date of signing. One unit per Medicaid recipient per provider is allowed without prior authorization. If determined by OHCA or its designated agent, one additional unit per year may be authorized.

**(6) Alcohol and/or Substance Abuse Treatment Plan Development (low complexity).** Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) is for the purpose of reviewing, revising and updating an established Mental Health Services Plan. The ASAM criteria will be utilized in the development of the Plan. All elements of the plan must be reviewed with the client and treatment progress assessed. When significant progress toward recovery and the treatment goals is not occurring, the service plan must be altered in order to support and maximize progress toward recovery. When significant progress has been made, the plan must be updated to reflect the improved client's abilities and strengths and services adjusted accordingly. Alcohol and/or Substance Abuse Treatment Plan Development (low complexity) will be provided by the treatment team members. The review is not valid until signed and separately dated by the responsible AODTP, the responsible physician (if client is receiving medication or otherwise under the care of the physician), the client, the guardian (if applicable), and any other direct service provider, and all requirements have been met.

**(7) Individual/Interactive Psychotherapy.**

(A) Individual Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification

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techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change.

(B) Interactive Psychotherapy is generally furnished to children and involves the use of physical aids and nonverbal communication to overcome barriers to the therapeutic interaction between the clinician and the client who has not yet developed or who has lost either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician. The service may be used for adults who are hearing impaired and require the use of a language interpreter due to language barriers.

(C) There are a total of six different compensable units of individual/interactive psychotherapy, three each for interactive and individual psychotherapy. They are Individual Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy in an Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes), and Interactive Psychotherapy in an office or Outpatient Setting (20 - 30 minutes, 45 - 50 minutes, and 75 - 80 minutes). There is a maximum of one unit of either Individual or Interactive Psychotherapy per day. With the exception of a qualified interpreter if needed, only the client and the MHP or AODTP should be present and the setting must protect and assure confidentiality. Ongoing assessment of the client's status and response to treatment as well as psycho-educational intervention are appropriate components of individual counseling. The counseling must be goal directed, utilizing techniques appropriate to the service plan and the client's developmental and cognitive abilities.

(D) Individual/Interactive counseling must be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

**(8) Group Psychotherapy.**

(A) Group psychotherapy is a method of treating behavioral disorders using the interaction between the MHP when treating mental illness or the AODTP when treating alcohol and other drug disorders, and two or more individuals to promote

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positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual client's current service plan. This service does not include social or daily living skills development as described under Individual and Group Psychosocial Rehabilitation Services, or Alcohol and/or Substance Abuse Services Skills Development.

(B) Group Psychotherapy must take place in a confidential setting limited to the MHP or the AODTP conducting the service, an assistant or co-therapist, if desired, and the group psychotherapy participants. Group Psychotherapy is limited to a total of eight adult individuals except when the individuals are residents of an ICF/MR where the maximum group size is six. For all children under the age of 18, the total group size is limited to six. The typical length of time for a group psychotherapy session is one hour. A maximum of two Group Psychotherapy units per day are allowed. Partial units are acceptable. The individual client's behavior, the size of the group, and the focus of the group must be included in each client's medical record. A group may not consist solely of related individuals.

(C) Group psychotherapy will be provided by a MHP when treatment is for a mental illness and by an AODTP when treatment is for an alcohol or other drug disorder.

**(9) Family Psychotherapy.**

(A) Family Psychotherapy is a face-to-face psychotherapeutic interaction between a MHP or an AOD and the client's family, guardian, and/or support system. It is typically inclusive of the identified client, but may be performed if indicated without the client's presence. When the client is an adult, his/her permission must be obtained. Family psychotherapy must be provided for the direct benefit of the Medicaid recipient to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting.

(B) The length of a Family Psychotherapy session is one hour. No more than two hours of Family Psychotherapy are allowed per day. Partial units are acceptable. Family Psychotherapy must be provided by a MHP when treatment is for a mental

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illness and by an AODTP when treatment is for an alcohol or other drug disorder.

**(10) Psychosocial Rehabilitation Services (group).**

(A) Psychosocial Rehabilitation Services (PSR) are behavioral health remedial services which are necessary to improve the client's ability to function in the community. They are performed to improve the skills and abilities of clients to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may take the form of a work units component in a General PSR program certified through the ODMHSAS. Each day of PSR must be reflected by documentation in the client records, and must include the following:

- (i) date;
- (ii) start and stop time(s) for each day of service;
- (iii) signature of the rehabilitation clinician;
- (iv) credentials of the rehabilitation clinician;
- (v) specific goal(s) and/or objectives addressed (these must be identified on recovery plan);
- (vi) type of skills training provided;
- (vii) progress made toward goals and objectives;
- (viii) client satisfaction with staff intervention; and
- (ix) any new needed supports identified during service.

(B) Compensable Psychosocial Rehabilitation Services are provided to clients who have the ability to benefit from the service. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

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(C) Travel time to and from PSR treatment is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each BHRS or MHP for adults and eight to one for children under the age of eighteen. Countable professional staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE. In order to develop and improve the client's community and interpersonal functioning and self care abilities, rehabilitation may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the BHRS or MHP must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service.

(D) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder), or MHP may perform group psychosocial rehabilitation services, using a treatment curriculum approved by a MHP.

**(11) Psychosocial Rehabilitation Services (individual).**

(A) Psychosocial Rehabilitation (PSR) Services (individual) is performed for the same purposes and under the same description and requirements as Psychosocial Rehabilitation Services (group) [Refer to paragraph (10) of this subsection]. The service is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

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(B) A BHRS, AODTP (when treatment is for an alcohol or other drug disorder, or MHP must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

**(12) Psychological testing.**

(A) Psychological testing is provided by a psychologist utilizing tests selected from currently accepted psychological test batteries. Test results must be reflected in the Mental Health Services plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) Psychological testing will be provided by a psychologist, certified psychometrist, or a psychological technician of a psychologist.

**(13) Alcohol and/or Substance Abuse Services, Skills Development (group).**

(A) Alcohol and/or Substance Abuse Services, Skills Development (group) consists of the therapeutic education of clients regarding their AOD addiction or disorder. The service may also involve teaching skills to assist the individual in how to live independently in the community, improve self care and social skills and promote and support recovery. The services performed must have a purpose that directly relates to the goals and objectives of the client's current service plan. A client who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.

(B) Travel time to and from Alcohol and/or Substance Abuse Services, Skills Development is not compensable. Breaks, lunchtime and times when the client is unable or unwilling to participate are not compensable. The minimum staffing ratio is fourteen clients for each AODTP for adults and eight to one for children under the age of eighteen. This service may

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be performed by an AODTP or a BHRS. In order to develop and improve the client's community and interpersonal functioning and self care abilities, services may take place in settings away from the Outpatient Behavioral Health agency site. When this occurs, the AODTP or BHRS must be present and interacting, teaching, or supporting the defined learning objectives of the client for the entire claimed time. The service is a fifteen minute time frame and may be billed up to a maximum of 24 units per day for adults and 16 units per day for children. The rate of compensation for this service includes the cost of providing transportation for recipients who receive this service, but do not have their own transportation or do not have other support persons able to provide or who are responsible for the transportation needs. The OHCA transportation program will arrange for transportation for those who require specialized transportation equipment. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service.

(C) Alcohol and/or Substance Abuse Services, Skills Development are provided utilizing a treatment curriculum approved by an AODTP.

**(14) Alcohol and/or Substance Abuse Services, Skills Development (individual).**

(A) Alcohol and/or Substance Abuse Services, Skills Development (individual) is performed for the same purposes and under the same description and requirements as Alcohol and/or Substance Abuse Services, Skills Development (group) [Refer to paragraph (13) of this subsection]. It is generally performed with only the client present, but may include the client's family or support system in order to educate them about the rehabilitative activities, interventions, goals and objectives.

(B) An AODTP or BHRS must provide this service. Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic Foster Home are not eligible for this service. This billing unit is fifteen minutes and no more than six units per day are compensable.

**(15) Medication Training and Support.**

(A) Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a client's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the progress notes. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the client on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for Medicaid recipients who reside in ICF/MR facilities.

(B) Medication Training and Support must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

**(16) Crisis Intervention Services.**

(A) Crisis Intervention Services are for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal or severe psychiatric distress. The crisis situation including the symptoms exhibited and the resulting intervention or recommendations must be clearly documented. Crisis Intervention Services are not compensable for Medicaid recipients who reside in ICF/MR facilities, or who receive RBMS in a group home or Therapeutic Foster home, or recipients who, while in attendance for other behavioral health services, experience acute behavioral or emotional dysfunction. The unit is a fifteen minute unit with a maximum of eight units per month and 40 units each 12 months per recipient.

(B) Crisis Intervention Services must be provided by a MHP.

**(17) Crisis Intervention Services (facility based stabilization).** Crisis Intervention Services (facility based stabilization) are emergency psychiatric and substance abuse services to resolve crisis situations. The services provided are emergency stabilization, which includes a protected

environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis Intervention Services (facility based stabilization) will be under the supervision of a physician aided by a licensed nurse, and will also include MHPs for the provision of group and individual treatments. A physician must be available. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system. Crisis Intervention Services (facility based stabilization) are compensable for child and adult Medicaid recipients. The unit of service is per hour. Providers of this service must meet the requirements delineated in the Oklahoma Administrative Code.

**(18) Program of Assertive Community Treatment (PACT) Services.**

(A) Program of Assertive Community Treatment (PACT) Services are those delivered within an assertive community based approach to provide treatment, rehabilitation, and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self contained multi-disciplinary team. The team must use an integrated service approach to merge essential clinical and rehabilitative functions and staff expertise. This level of service is to be provided only for persons most clearly in need of intensive ongoing services. Services must satisfy all statutory required program elements as articulated in the Oklahoma Administrative Code 450:55. At a minimum, the services must include:

(i) Assessment and evaluation;

(ii) Treatment planning;

(iii) Crisis intervention to cover psychiatric crisis and drug and alcohol crisis intervention;

(iv) Symptom assessment, management, and individual supportive psychotherapy;

(v) Medication evaluation and management, administration, monitoring and documentation;

(vi) Rehabilitation services;

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- (vii) Substance abuse treatment services;
- (viii) Activities of daily living training and supports;
- (ix) Social, interpersonal relationship, and related skills training; and,
- (x) Case management services.

(B) Providers of PACT services are specific teams within an established organization and must be operated by or contracted with and must be certified by the ODMHSAS in accordance with 43A O.S. 319 and Oklahoma Administrative Code 450:55. The unit is a per diem inclusive of all services provided by the PACT team. No more than 12 days of service per month may be claimed. Medicaid recipients who are enrolled in this service may not receive other Outpatient Behavioral Health Services except for Crisis Intervention Services (facility based stabilization).

(19) Behavioral Health Aide. This service is limited to children with serious emotional disturbance who are in an ODMHSAS contracted systems of care community based treatment program who need intervention and support in their living environment to achieve or maintain stable successful treatment outcomes. Behavioral Health Aides provide behavior management and redirection and behavioral and life skills remedial training. The behavioral aide also provides monitoring and observation of the child's emotional/behavioral status and responses, providing interventions, support and redirection when needed. Training is generally focused on behavioral, interpersonal, communication, self help, safety and daily living skills.

(A) Behavioral Health Aides must have completed 60 hours or equivalent of college credit to meet the requirement as a BHRS or may substitute one year of relevant employment and/or responsibility in the care of emotionally disturbed children for up to two years of college experience, and:

- (i) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS;  
and
- (ii) must be directly and closely supervised by a licensed

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Mental Health Professional; and

(iii) function under the general direction of the established systems of care team and the current treatment plan.

(B) These services must be prior authorized by OHCA (or its designated agent).

**(b) Prior authorization and review of services requirements.**

**(1) General requirement.**

(A) All Medicaid providers who provide outpatient behavioral health services are required to have the services they provide either prior authorized or retroactively reviewed by a contractor of OHCA. Private behavioral health providers and providers identified by the ODMHSAS as contracted providers are required to have all services prior authorized with the exception of the three services listed in paragraph (2)(A) of this subsection.

(B) CMHC's, as identified by the ODMHSAS, are required to have all services retroactively reviewed by a contractor of OHCA.

**(2) Prior authorization and review of services.**

(A) All Medicaid services identified in subsection (a) of this Section must be prior authorized or reviewed as set forth in paragraph (1) of this subsection except for the following services:

(i) Mental Health Assessment by a Non-Physician [see subsection (a)(1) of this Section];

(ii) Mental Health Services Plan Development by a Non-Physician (moderate complexity) [see subsection (a)(2) of this Section]; and

(iii) Crisis Intervention Services and Adult Facility Based Crisis Intervention [see subsection (a)(17) and (18) of this Section]. Children's Facility Based Stabilization requires prior authorization.

(B) Prior authorization means the authorization of services prior to services being rendered. Should a provider perform services prior to the authorization, those services are performed at the risk of nonpayment by OHCA.

(3) Contractor for prior authorization and review of services.  
The contractor who performs the services identified in paragraph (1) of this subsection uses its independent medical judgment to perform both the review of services and the prior authorization of services. OHCA does retain final administrative review over both prior authorization and review of services as required by 42 CFR 431.10.

(4) Prior authorization process.

(A) Definitions. The following definitions apply to the process of applying for an outpatient behavioral health prior authorization.

(i) "Outpatient Request for Prior Authorization" means the form used to request the OHCA contractor to approve services.

(ii) "Authorization Number" means the number that is assigned per recipient and per provider that authorizes payment after services are rendered.

(iii) "Initial Request for Treatment" means a request to authorize treatment for a recipient that has not received outpatient treatment in the last six months.

(iv) "Extension Request" means a request to authorize treatment for a recipient who has received outpatient treatment in the last six months.

(v) "Modification of Current Authorization Request" means a request to modify the current array or amount of services a recipient is receiving.

(vi) "Correction Request" means a request to change a prior authorization error made by OHCA's contractor.

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(vii) "Provider change in demographic information notification" means a request to change a provider's name, address, phone, and/or fax numbers, or provider identification numbers. Change in demographics will require contractual changes with OHCA. Providers should contact OHCA's Contracts Services Division for more information.

(viii) "Status request" means a request to ask the OHCA contractor the status of a request.

(ix) "Important notice" means a notice that informs the provider that information is lacking regarding the approval of any prior authorization request.

(x) "Letter of collaboration" means an agreement between the recipient and two providers when a recipient chooses more than one provider during a course of treatment.

(B) **Process.** A provider must submit an Initial Request for Treatment, an Extension Request, a Modification of Current Authorization Request, or a Correction Request on a form provided by the OHCA contractor, prior to rendering the initial services or any additional array of services, with the exception of the three services noted in paragraph (2) of this subsection.

(i) These request forms must be fully completed including the following:

(I) pertinent demographic and identifying information;

(II) complete and current Client Assessment Record (CAR) unless another appropriate assessment tool is authorized by contractor;

(III) complete multi axial, Diagnostic and Statistical Manual (DSM) diagnosis using the most current edition;

(IV) psychiatric and treatment history;

(V) service plan with goals, objectives, treatment duration;

(VI) services requested;

(VII) signature of client on service plan; and

(VIII) appropriate provider signature on all forms.

(ii) The OHCA contractor may also require supporting documentation for any data submitted by the provider. The request may be denied if such information is not provided within ten calendar days of notification of the Important Notice.

(iii) Failure to provide a complete request form may result in a delay in the start date of the prior authorization.

**(C) Authorization for services.**

(i) Services are authorized by the contractor exercising independent medical judgment based upon the medical data provided by the provider. The medical data provided, including the functional assessment (including frequency, duration and severity of behaviors), diagnosis and other medical history, is of paramount importance. If services are authorized, a treatment course of one to six months will be authorized. The authorization of services is based upon six levels of care for children and five levels of care for adults. The numerically based levels of care are designed to reflect the client's acuity as each level of care, in ascending order, provides for more services for the recipient's care. For example, a Level I (adult) designation provides for 1-12 RVU's while a Level II provides for 1-20 RVU's per month. The range of RVU's between the Level I and Level IV for both children and adults is 1 RVU per month to 62 RVU's per month. Other levels of care are known as Exceptional Case, 0-36 months, ICF/MR, and RBMS.

(ii) If the provider requests services beyond the initial prior authorization period, additional documentation is required in the Extension Request.

**(D) Appeals process.**

(i) After the contractor issues a decision regarding an Initial Prior Authorization request, an Extension Request, a Modification Request or a Correction Request, the provider has five business days of receipt of the decision to request the contractor to reconsider its decision. The issues which a provider may ask for reconsideration are the number and type of services designated by the contractor and the length of treatment approved by the contractor. The reasoning or propriety of an Important Notice or a denial based upon insufficient data may not be reconsidered.

(ii) If a reconsideration request is made, the contractor's decision is a final decision and notice is sent to the client as required by 42 CFR 431.211. Notice is also sent to the provider. If a reconsideration request is not made, the initial decision of the contractor constitutes the final decision regarding the authorization and notice is sent to the recipient as required by 42 CFR 431.211.

(iii) In the event a recipient disagrees with the decision by OHCA's contractor, it may appeal the decision regarding the prior authorization under OAC 317:2-1-2. An appeal must commence within 20 calendar days of the prior authorization reconsideration decision (in the event the provider asks for reconsideration) or within 20 days of the initial decision (in the event no reconsideration request is filed).



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**317:30-5-248. Documentation of records**

All outpatient behavioral health services must be reflected by documentation in the patient records.

(1) All assessment and treatment services must include the following:

- (A) date;
- (B) start and stop time for each timed treatment session;
- (C) signature of the therapist/service provider;
- (D) credentials of therapist/service provider;
- (E) specific problems(s), goals and/or objectives addressed (these must be identified on master treatment plan);
- (F) methods used to address problem(s), goals and objectives;
- (G) progress made toward goals and objectives;
- (H) patient response to the session or intervention; and
- (I) any new problem(s), goals and/or objectives identified during the session.

(2) In addition to the items listed in (1) of this subsection:

- (A) Crisis Intervention Service notes must also include:
  - (i) a detailed description of the crisis; and
  - (ii) level of functioning assessment.
- (B) For each Group rehabilitative or counseling session a list of participants and facilitating BHRS, MHP, or AODTP must be maintained.
- (C) For medication training and support, vital signs must be recorded in the progress note, but are not required on the mental health services plan.



**317:35-5-41. Determination of capital resources for individuals categorically related to aged, blind and disabled**

(a) **General.** The term capital resources is a general term representing any form of real and/or personal property which has an available money value. All available capital resources, except those required to be disregarded by law or by policies of the OHCA or OKDHS are considered in determining need. Available resources are those resources which are in hand or under the control of the individual.

(1) In defining need, OHCA and OKDHS recognize the importance of a recipient retaining a small reserve for emergencies or special need and has established a maximum reserve a client or family may hold and be considered in need.

(2) Capital resources are evaluated on a monthly basis in determining eligibility for an applicant for medical services. An applicant is determined ineligible for any month resources exceed the resource standard at any time during that month. When a recipient has resources which exceed the resource standard, case closure action is taken for the next possible effective date. ■ 1

(3) State law is specific on the mutual responsibility of spouses for each other. Therefore, if husband and wife are living together, a capital resource and/or income available to one spouse constitutes a resource and/or income to the other. When there is a break in the family relationship and the husband and wife are separated, but not divorced or legally separated, they constitute a possible resource to each other and this possible resource is explored to determine what, if any, resource can be made available. ■ 1 When spouse is in a nursing facility, see Subchapter 9 and 19 of this Chapter.

(4) Household equipment used for daily living is not considered a resource.

(5) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The recipient may change the form of capital resources from time to time without affecting eligibility so long as the equity is not decreased in doing so or increased in excess of the allowable maximum reserve. In the event the equity is decreased as the result of

a sale or transfer, the reduction in the equity is evaluated in relation to policy applicable to resources disposed of while receiving assistance. ■ 2

(b) **Eligibility.** In determining eligibility based on resources, only those resources available for current use or those which the client can convert for current use (no legal impediment involved) are considered as countable resources. Examples of legal impediments include, but are not limited to, clearing an estate, probate, petition to sell or appointment of legal guardian.

(1) Generally, a resource is considered unavailable if there is a legal impediment to overcome. However, the client must agree to pursue all reasonable steps to initiate legal action within 30 days. While the legal action is in process, the resource is considered unavailable.

(2) If a determination is made and documented that the cost of making a resource available exceeds the gain, the client will not be required to pursue action to make it available.

(3) Determination of available and unavailable resources must be well documented in the case record.

(4) The major types of capital resources are listed in (c) and (d) of this Section. The list is not intended to be all inclusive and consideration must be given to all resources.

(c) **Home/real property.** Home property is excluded from resources regardless of value. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. ■ 3 Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as outlines in OAC 317:35-5-41(c)(6). Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.

(1) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or

other necessity. The OHCA has not set a definite time limit to the client's absence from the home. When it is determined that the client does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the reserve. The client is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the client is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised in writing that the 90-day period begins with the determination that the property be considered in relation to the reserve. The 90-day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the client, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the client. A written notification is also provided to the client at any time an extension is allowed. Detailed documentation in the case record is required.

(2) If the client fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the client is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum reserve provided other conditions of eligibility continue to be met.

(3) When a recipient sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to be not in excess of a 90-day period. Extensions beyond the 90 days may be justified only after interviewing the client, determining that a good faith effort is still being made and that completion of the transaction is beyond his/her control. This must be documented in the case record.

(4) At the point a recipient decides not to reinvest the proceeds from the sale of his/her home in another home, the recipient's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(5) A home traded for another home of equal value does not affect the recipient's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(6) Absences from home for up to 90 days for trips or visits of six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence. Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The Acknowledgment of Temporary Absence/Home Property Policy form is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the client, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For recipients in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the recipient when it has been determined, after notice and opportunity for a hearing, that the recipient cannot reasonably be expected to be discharged and return home. However, a lien shall not be filed on the home property of the recipient while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for Medicaid benefits, and ■ 4

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the recipient will be discharged from the facility and return home and a lien

may be filed against real property owned by the client for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the client to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A client who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, halfsister, halfbrother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.

(H) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with the home property are considered as a resource. Since evaluation and salability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through

a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property.

(8) The market value of real estate other than home property owned by the client or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the client of a merchantable title to be determined when the reserve approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral and/or written information which the applicant has on hand **and** counsel with persons who have specialized knowledge about this kind of resource. Refer to (12) of this subsection for exclusion of real estate that produces income.

(9) Land which is held by an enrolled member of an Indian tribe is excluded from resources as it cannot be sold or transferred without the permission of other individuals, the tribe, or a federal agency. If permission is needed, the land is excluded as a resource.

(10) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the client's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the property and the age of the life estate owner. ■ 5

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the client does not accept as valid the value of the life estate as established through this method, the client will secure written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the client will jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current market values and who is acceptable to both the client and the worker.

(11) Homestead rights held by a client in real estate provide the client with shelter (or shelter and income) so long as he/she resides on the property. Payment for care in a nursing facility provided to the recipient through Medicaid constitutes a waiver of the homestead rights of the recipient. If the client moves from the property, a lien is filed, or the client otherwise abandons his/her homestead rights, the property becomes subject to administration. Since a homestead right cannot be sold, it does not have any value.

(12) Real and/or personal property which produces income is excluded if it meets the following conditions.

(A) **Trade or business property.** The existence of a trade or business may be established through business tax returns that would be used to compute self-employment earnings. If the current business tax return is unavailable, the existence of the business may be determined through other business forms, records, partnership, a detailed description of the business and its activities, etc. Once it is established that a trade or business exists, any property (real or personal) connected to it and in current use is excluded. This exclusion includes liquid assets, such as a bank account(s) necessary for the business operation. All property used by a trade or business and all property used by an employee in connection with employment is excluded as property essential to self support. The income from the trade or business is determined as any other self-employment income.

(B) **Non-trade or non-business property.** Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed \$6000, and the net return equals at least 6% of the equity annually. An equity value in excess of \$6000 is a countable resource. If

the equity exceeds \$6000 and 6% return is received on the total equity, only the amount in excess of \$6000 is a countable resource. An annual return of less than 6% is acceptable if it is beyond the individual's control, and there is a reasonable expectation of a future 6% return. Liquid resources cannot be excluded as income producing property or meeting the \$6000/6% rule (mortgages, including contract for deed, and notes which are income producing are considered as liquid resources). The \$6000/6% rule applies to all resources in total, and not separately. Examples of non-business income producing property are rental property, timber rights, mineral rights, etc.

**(d) Personal property.**

**(1) Property used to produce goods and services.** Personal property necessary to perform daily activities or to produce goods for home consumption is excluded if the equity value does not exceed \$6000. An equity value in excess of \$6000 is a countable resource. The property does not have to produce a 6% annual return. The \$6000 equity maximum includes all such resources in total and does not pertain to each item separately. Examples of property used to produce goods and services are tractors, woodcutting tools, mechanized equipment for gardening, livestock grown for home consumption, etc.

**(2) Cash savings and bank accounts.** Money on hand or in a savings account is considered as reserve. The client's statement that he/she does not have any money on hand or on deposit is sufficient unless there are indications to the contrary. When there is information to the contrary or when the client does not have records to verify the amount on deposit, verification is obtained from bank records. Title 56, O.S., Section 1671 provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the client or the Agency.

(A) Checking accounts may or may not represent savings. Current bank statements are evaluated with the client to establish what, if any, portion of the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.

(B) Accounts which are owned jointly by the client and a non-

recipient person are considered available to the client in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the recipient is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.

(3) **Life insurance policies.** If the total face value of all life insurance policies owned by an individual is \$1500 or less, the policies (both face value and cash surrender value) are excluded as resources.

(A) If the total face value of all policies owned by an individual exceeds \$1500, the net cash surrender value of such policies must be counted as resources. Life insurance policies which do not provide a cash surrender value (e.g., term insurance) are not used in determining whether the total face value of all policies is over \$1,500.

(B) The face value of a life insurance policy which has been assigned to fund a prepaid burial contract must be evaluated and counted according to the policy on burial funds or, if applicable, the policy on the irrevocable burial contract.

(C) The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon) usually can be verified by inspection of the insurance policies and documents in the client's possession or by use of the Request to Insurance Company form.

(D) Dividends which accrue and which remain with the insurance company increase the amount of reserve. Dividends which are paid to the client are considered as income.

(E) If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable as a resource in the following months to the extent it is available. The payment of such benefits is not considered a

conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

(4) **Burial spaces.** The value of burial spaces for an individual, the individual's spouse or any member of the individual's immediate family will be excluded from resources. "Burial spaces" means conventional gravesites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons. "Immediate family" means individual's minor and adult children, including adopted children and step-children; and individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member.

(5) **Burial funds.** Revocable burial funds not in excess of \$1500 are excluded as a resource if the funds are specifically set aside for the burial arrangements of the individual or the individual's spouse. Any amount in excess of \$1500 is considered as a resource. Burial policies which require premium payments and do not accumulate cash value are not considered to be prepaid burial policies.

(A) "Burial funds" means a prepaid funeral contract or burial trust with a funeral home or burial association which is for the individual's or spouse's burial expenses.

(B) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (5)(A) of this subsection.

(C) The burial fund exclusion must be reduced by the face value of life insurance policies owned by the individual or spouse; and amounts in an irrevocable trust or other irrevocable arrangement.

(D) Interest earned or appreciation on the value of any excluded burial funds are excluded if left to accumulate and become a part of the burial fund.

(E) If the client did not purchase his/her own prepaid

burial, even if his/her money was used for the purchase, the client is not the "owner" and the prepaid burial funds cannot be considered a resource to him/her. However, if the client's money was used by another to purchase the prepaid burial, the rules on transfer of property must be applied since the purchaser (owner) could withdraw the funds any time.

(6) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. The irrevocability cannot become effective until 30 days after purchase.

(A) If the irrevocable election was made prior to July 1, 1986 and the client received assistance on July 1, 1986, the full amount of the irrevocable contract is not considered a countable resource. This exclusion applies only if the client does not add to the amount of the contract. Interest accrued on the contract is not considered as added by the client. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (B) of this paragraph.

(B) If the effective date for the irrevocable election or application for assistance is July 1, 1986 or later:

(i) the face value amount in an irrevocable contract cannot exceed \$7,500, plus accrued interest.

(ii) a client may exclude the face value, up to \$7,500, plus accrued interest in any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed \$1500. When the amount exceeds \$7,500, the client is ineligible for assistance. Accrued interest is not counted as a part of the \$7,500 limit regardless of when it is accrued. ■ 6

(iii) the face value of life insurance policies used to fund burial contracts is counted towards the \$7,500 limit.

■ 7

(C) For an irrevocable contract to be valid, the election to

make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner).

(D) In instances where Management of Recipient's Funds form is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the client.

(7) **Medical insurance.** When a client has medical insurance, the available benefits are applied toward the medical expense for which the benefits are paid. The type of insurance is clarified in the record. If an assignment of the insurance is not made to the provider and payment is made directly to the client, the client is expected to apply the payment to the cost of medical services. Any amount remaining after payment for medical services is considered in relation to the reserve.

(8) **Stocks, bonds, mortgages and notes.** The client's equity in stocks and bonds (including U.S. Savings Bonds series A thru EE) is considered in relation to the reserve. The current market value less encumbrances is the equity. In general, determination of current market value can be obtained from daily newspaper quotations, brokerage houses, banks, etc.

(A) The current value of U.S. Savings bonds which have been held beyond the maturity date is the redemption value listed in the table on the back of the bond for the anniversary date most recently reached. If the bond has been held beyond maturity date, it has continued to draw interest. An acceptable determination of the value may be made by checking against a chart at the bank.

(B) The amount which can be realized from notes and mortgages and similar instruments, if offered for immediate sale, constitutes a reserve. Notes and mortgages and similar instruments have value regardless of whether there is an actual offer. Appraisals obtained from bankers, realtors, loan companies and others qualified to make such estimates are obtained in determining current market value. When a total reserve approaches the maximum, it is desirable to get two or more estimates.

(C) Mortgages (including contracts for deed) and notes which are income producing are liquid countable resources.

(9) **Trust accounts.** Monies held in trust for an individual applying for or receiving Medicaid must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, etc., or the Bureau of Indian Affairs (BIA).

(A) **Availability determinations.** The social worker should be able to determine the availability of a trust using the definitions and explanations listed in (B) of this subsection. However, in some cases, the worker may wish to submit a trust to the OKDHS State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(B) **Definition of terms.** The following words and terms, when used in this paragraph, shall have the following meaning, unless the context clearly indicates otherwise:

(i) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(ii) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(iii) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(iv) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(v) **Grantor (trustor/settlor).** Grantor (trustor/settlor)

means the individual who establishes the trust by transferring certain assets.

(vi) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(vii) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(viii) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(ix) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(x) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(xi) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(xii) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(C) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving Medicaid, copies of the following documents are obtained:

(i) Trust document;

(ii) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(iii) Documentation reflecting prior disbursements (date, amount, purpose).

(D) **Trust accounts established on or before August 10, 1993.** The rules found in (i) - (iii) of this subparagraph apply to trust accounts established on or before August 10, 1993.

(i) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (I)-(III) of this unit, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(I) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(II) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(III) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available.

If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that Medicaid benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(ii) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to Title 12 Oklahoma Statute ' 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for Medicaid; and, whether or not discretion is actually exercised.

(I) **Similar legal device.** MQT rules listed in of this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the client petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(II) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the client. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the client can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the client, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the client (or to use it for the client's benefit), the entire principal is an available resource to the client. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the client (or to be used for his/her benefit), but those distributions are not made, the client's countable resources increase cumulatively by the undistributed amount.

(III) **Income treatment.** Amounts of MQT income distributed to the client are countable income when distributed. Amounts of income distributed to third parties for the client's benefit are countable income when distributed.

(IV) **Transfer of resources.** If the MQT is irrevocable,

a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the client or using it for the client's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the client, the principal is not an available resource and has, therefore, been transferred).

(iii) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including Medicaid benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including Medicaid benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(E) **Trust accounts established on or after August 11, 1993.** The rules found in (i) - (iii) of this subparagraph apply to trust accounts established on or after August 11, 1993.

(i) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(I) the individual;

(II) the individual's spouse;

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

(IV) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(ii) Where trust principal includes assets of an

individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(iii) There are two types of trusts, revocable trusts and irrevocable trusts.

(I) In the case of a revocable trust, the principal is considered an available resource to the individual. Home property in a revocable trust under the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41(c)(6). Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(II) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made shall be considered available resources. Payments from the principal or income of the trust shall be considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(F) **Exempt trusts.** Subparagraph (E) of this paragraph shall not apply to the following trusts:

(i) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(I) The trust may only contain the assets of the disabled individual.

(II) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(III) Trust records shall be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(IV) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(V) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.

(VI) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used

for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

(VII) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.

(VIII) The OKDHS Supplemental Needs Trust form is an example of the trust. Social workers may give the sample form to the client or his/her representative to use or for their attorney's use.

(IX) To terminate or dissolve a Supplemental Needs Trust, the social worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: HR&MS explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(ii) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(I) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1) but less than \$2500 per month.

(II) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources can not be included in the trust.

(III) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(IV) The trust must retain an amount equal to the client's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee shall distribute the remainder.

(V) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(VI) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records shall be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(VII) The State will receive all amounts remaining in the trust up to an amount equal to the total Medicaid benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(VIII) Accumulated funds in the trust may only be used for medically necessary items not covered by Medicaid, or other health programs or health insurance and a reasonable cost of administering the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(IX) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(X) An example trust is included on OKDHS form M-11. Social Workers may give this to the client or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(XI) To terminate or dissolve a Medicaid Income Pension

Trust, the social worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(iii) A trust containing the assets of a disabled individual when all of the following are met:

(I) The trust is established and managed by a non-profit association;

(II) The trust must be made irrevocable;

(III) The trust must be approved by the Department of Human Services and may not be amended without the permission of the Department of Human Services;

(IV) The disabled person has no ability to control the spending in the trust;

(V) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(VI) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the recipients;

(VII) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(VIII) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the

beneficiary's death may be retained by the trust.

(G) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands shall not be considered a resource in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(H) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

(10) **Retirement funds.** The rules regarding the countable value, if any, of retirement funds are found in subparagraph (A) - (B) of this paragraph:

(A) **Annuities.**

(i) Annuities purchased prior to February 1, 2005. An annuity gives the right to receive fixed, periodic payments either for life or a term of years. The annuity instrument itself must be examined to determine the provisions and requirements of the annuity. For example, it is determined whether the individual can access the principal of the annuity; e.g., can it be cashed in. If so, the annuity is treated as a revocable trust (OAC 317:35-5-41(d)(9)(E)(iii)(I). If the individual cannot access the principal, the annuity is treated as an irrevocable trust. In this instance, it must also be determined what part of the annuity can, under any circumstances, be paid to, or for the benefit of the individual. When making such a determination, the date of application is used or, if later, the date of institutionalization (for an institutionalized individual) or the date of creation of the annuity (for a non-institutionalized individual). Also, these dates are used in determining whether the transfer of asset provisions apply to a particular annuity. If the annuity provides for payments to be made to the individual, those payments would be considered income to the individual. Any portion of the principal of the annuity that could be paid to or

on behalf of the individual would be treated as a resource to the individual and portions of the annuity that cannot be paid to or for the benefit of the individual are treated as transfers of assets. Annuities may also be a transfer of assets for less than fair market value. The worker determines, in accordance with the OKDHS life expectancy tables, ■ 8 whether the client will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the client during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed. ■ 8

(ii) Annuities purchased after January 31, 2005.

(I) An annuity is presumed to be an available resource to the individual who will receive the payments because the annuity can be sold. The value of the annuity is the total of all remaining payments, discounted by the Applicable Federal Rate set by the IRS for the valuation of annuities for the month of application or review.

(II) The applicant or recipient may rebut the presumption that the annuity can be sold by showing compelling evidence to the contrary, in which case the annuity is not considered available. The applicant or recipient may also rebut the presumed annuity value by showing compelling evidence that the actual value of the annuity is less than the presumed value.

**(B) Other retirement investment instruments.** This subparagraph relates to individual retirement accounts (IRA), Keogh plans, profit sharing plans, and work related plans in which the employee and/or employer contribute to a retirement account.

(i) **Countability of asset.** In each case, the document governing the retirement instrument must be examined to determine the availability of the retirement benefit at the time of application. Retirement benefits are considered countable resources if the benefits are available to the applicant and/or spouse. Availability means that the applicant and/or spouse has an option to receive retirement benefits or is actually receiving

benefits. For example, a retirement instrument may make a fund available at the time of termination of employment, at age 65, or at some other time. A retirement fund is not a countable resource if the applicant is currently working and must terminate employment in order to receive benefits. An individual may have the choice of withdrawing the monies from the retirement fund in a single payment or periodic payments (i.e., monthly, quarterly, etc.). If the individual elects to receive a periodic payment, the payments are considered as income as provided in OAC 317:35-5-42(c)(3). If the monies are received as a lump sum, the rules at OAC 317:35-5-42(c)(3)(C)(i) apply.

(ii) **Asset valuation.** Valuation of retirement benefits is the amount of money that an individual can currently withdraw from the fund or is actually receiving. Valuation does not include the amount of any penalty for early withdrawal. Taxes due on the monies received by the applicant are not deducted from the valuation.

(iii) **Timing of valuation.** Retirement funds are a countable resource in the month that the funds are available to the applicant. For purposes of this subsection, the month that the funds are available means the month following the month of application for the funds. For example, the retirement instrument makes retirement funds available at age 65. The applicant turns 65 on January 1<sup>st</sup>. The applicant makes a request for the funds on February 1<sup>st</sup> and the monies are received on June 1<sup>st</sup>. The retirement fund would be considered as a countable resource in the month of March. The resource would not be counted in the month in which it is later received.

(11) **Automobiles, pickups, and trucks.** Automobiles, pickups, and trucks are considered in the eligibility determination for Medicaid benefits.

(A) **Exempt automobiles.** One automobile is excluded from counting as a resource to the extent its current market value (CMV) does not exceed \$4,500. The CMV in excess of \$4,500 is counted against the resource limit; or exempt one automobile, pickup or truck per family regardless of the value if it is

verified that the car is used:

(i) for medical services 4 times a year to obtain either medical treatment or prescription drugs; or

(ii) for employment purposes; or

(iii) especially equipped for operation by or transportation of a handicapped person.

(B) **Other automobiles.** The equity in other automobiles, pickups, and trucks is considered in relation to the reserve. The current market value, less encumbrances on the vehicle, is the equity. Only encumbrances that can be verified are considered in computing equity.

(i) The market value of each year's make and model is established on the basis of the "av'g. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports" which is provided monthly to each county office by the OKDHS State Office.

(ii) If a vehicle's listing has been discontinued in the NADA book, the household's estimate of the value of the vehicle is accepted unless the worker has reason to believe the estimate is incorrect.

(iii) The market value of a vehicle no longer operable is the verified salvage value.

(iv) In the event the client and worker cannot agree on the value of the vehicle, the client secures written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals or between the book value and one or more of these appraisals, the worker and the client jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current values and who is acceptable to both the client and the worker.

(12) **Resource disregards.** In determining need, the following are not considered as resources:

(A) The coupon allotment under the Food Stamp Act of 1977;

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

(C) Education grants (excluding Work Study) scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(D) 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:

(i) 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 agreement is not written, OKDHS Form ADM-103, 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 loan. When copies of written agreements or Form ADM-103 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.

(ii) 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) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(iii) Proceeds of a loan secured by an exempt asset are not an asset.

(E) Indian payments or items purchased from Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita 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 judgement funds, trust funds, interest or investment income accrued on such funds. Any

income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. 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;

(F) Special allowance for school expenses made available upon petitions (in writing) from funds held in trust for the student;

(G) Benefits from State and Community Programs on Aging (Title III) are disregarded. 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 earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(H) Payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Services Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(I) Payment to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(J) The value of supplemental food assistance received under the Child Nutrition Act or the special food services program for children under the National School Lunch Act;

(K) 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;

(L) 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;

(M) 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.);

(N) 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;

(O) 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;

(P) Interests of individual Indians in trust or restricted lands. However, any disbursements from the trust or the restricted lands are considered as income;

(Q) Resources set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of resources excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(R) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(S) A migratory farm worker's out-of-state homestead is disregarded if the farm worker's intent is to return to the homestead after the temporary absence;

(T) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in interment camps during World War II;

(U) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI

underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released; and

(V) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC:35-5-41(d)(9) regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment.

(e) **Changes in capital resources.** Rules on transfer or disposal of capital resources are not applicable. See OAC 317:35-9, OAC 317:35-17, and OAC 317:35-19 if the individual enters a nursing home or receives Home and Community Based Waiver Services, HCBWS/MR or ADvantage waiver services.

(1) **Resources of an applicant.** If the resource(s) of an applicant is in a form which is not available for immediate use, such as real estate, mineral rights, or one of many other forms, and the applicant is trying to make the resource available, the applicant may be certified and given a reasonable amount of time to make this available. A reasonable amount of time would normally not exceed 90 days. The client is notified in writing that a period of time not to exceed 90 days will be given to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the client, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the client.

(2) **Capital resources acquired while receiving assistance.** If the recipient acquires resources which increase his/her available reserve above the maximum, he/she is ineligible for assistance unless there are specific plans for using the resources in compliance with rules on "resources disposed of while receiving assistance". The term "using the resource" is construed to mean that the resource has been encumbered or actually transferred. If the facts show a reasonable delay in executing the plan to use the required resource or if the resource is in a form which is not available for immediate use

(such as real estate, mineral rights, or one of many other forms), and if efforts are in progress to make the resource available, the recipient is given a reasonable amount of time to make this available. The client is notified in writing that a period of time not to exceed 90 days will be given to make the resources available. ■ 9

(A) Any extension beyond the initial 90 day period is justified only after interviewing the client, determining that a good faith effort is still being made and that failure to make the resource available is due to circumstances beyond the control of the client.

(B) Money borrowed on any of the client's resources, except the home, merely changes his/her resource from one form to another. Money borrowed on the home is evaluated in relation to the reserve.

(f) **Maximum reserve.** Maximum reserve is a term used to designate the largest amount which a recipient can have in one or more nonexempt resources, and still be considered to be in need. A recipient's reserve may be held in any form or combination of forms. If the resources of the applicant or recipient exceed the maximums listed on OKDHS Appendix C-1, he/she is not eligible.

(1) For each minor blind or disabled child up to the legal age of 18 living with parent(s) whose needs are not included in a TANF grant, or receiving SSI and/or SSP, the resource limit is the same as the individual limit as shown on OKDHS Appendix C-1.

If the parent's resources exceed the maximum amount, the excess is deemed available to the child (resources of an ineligible child are not deemed to an eligible child). If there is more than one eligible child, the amount is prorated.

(2) If the minor blind or disabled child up to the legal age of 18 is residing in a nursing facility, or a medical facility if the confinement lasts or is expected to last for 30 days, the parent(s)' resources are not deemed to the child.

(3) Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents resources are not deemed to the child until the month following the month in which the child leaves the hospital and begins

living with his/her parents.

(4) when both parents are in the home and one parent is included in an aged, blind or disabled case and the spouse is included in an TANF case with the children, the resources of both parents are evaluated in relation to eligibility for SSI and therefore not considered on the AFDC case. All resources of the parents would be shown on the aged, blind or disabled case.

**INSTRUCTIONS TO STAFF**

1. When the applicant is in a NF, see OAC 317:35-19-21. If the individual is receiving ADvantage Services, see OAC 317:35-17-11.
2. See OAC 317:35-5-41(e).
3. Property that is separated from the home by a street, highway, stream or other body of water, etc., is considered part of the home property.
4. Example: Client is admitted to the facility 10-28-92 and the 12-month exclusion ends 10-29-93. Appropriate case action to end the exemption of home property is taken effective 11-1-93.
5. For life estate computations, use online transaction LEC. Instructions for this transaction may be viewed by entering M(sp)LEC.
6. The information in 35-5-41(d)(3) is not applicable when determining the amount of irrevocable burial.
7. According to the Oklahoma State Insurance Commission, a funeral home cannot be the beneficiary of a life insurance policy used to fund a burial contract. Therefore, when life insurance is used to fund a burial contract, there must be an irrevocable assignment of proceeds to the funeral home.
8. Refer to DHS Appendix M-13, Medicaid Life Expectancy Table.
9. Detailed documentation in the case record is required.