
POLICY TRANSMITTAL NO. 10-55	DATE: DECEMBER 22, 2010
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF INTERGOVERNMENTAL RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:2-1-2; 2-1-5 through 2-1-7; 2-1-13; 30-3-28; 30-5-72.1; 30-5-77 through 30-5-78.1; 35-5-25; 35-23-2; 45-3-3; and 45-5-3.

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

Agency rules are revised regarding provider program integrity audits/reviews appeals to comply with Section 1011.9 of Title 56 of Oklahoma Statutes. These revisions allow for the recoupment of overpayments due to identified errors determined not to be fraudulent only after a provider has had the opportunity to exercise the right to an appeal that includes a hearing conducted by an administrative law judge appointed by the Oklahoma Attorney General. Rules also clarify that a provider has the right to participate in the hearing and to be represented by legal counsel.

OHCA policy is revised to create rules for the new Oklahoma Electronic Health Records Incentive Payment Program, which will begin January 2011 and is authorized by the American Recovery and Reinvestment Act of 2009. The rules provide a basic governing structure for the program, including the delineation of eligible providers and eligible hospitals, patient volume requirements, and incentive payment processes.

Pharmacy rules are revised to reflect the change in pricing methodology for injectable drugs that are submitted through the pharmacy system. Policy revisions are needed to clarify payment methodology and reduce expenditures. This change ensures compliance with the Oklahoma Constitution, Article X, Section 23 which prohibits a state agency from spending more money than is allocated. As a result, when dispensed through a pharmacy, the provider will be reimbursed at a rate which is equivalent to the Medicare rate plus the standard dispensing fee. Additional revisions include the coverage of non-prescription EPSDT products offered through the pharmacy point of sale system and the exemption of I/T/U facilities from prior authorization requirements for brand name drugs.

OHCA eligibility rules are revised to comply with new Federal law that eliminates the five-year bar on SoonerCare services for Afghan and Iraqi special immigrants. Previously, Afghan and Iraqi special immigrants were eligible for SoonerCare services for eight months and then were required to wait five years before they became eligible again. New policy eliminates the five-year bar so Afghan and Iraqi special immigrants may continue to receive SoonerCare services after eight months.

Rules are revised to include new eligibility criteria for individuals transitioning from an institution to a home and community based setting through the Living Choice Demonstration program. Current rules require individuals to be institutionalized for a minimum of 6 months and be SoonerCare eligible for at least 30 days. Section 2403 of the Patient Protection and Affordable Care Act reduces the institutional stay requirement to a minimum of 90 consecutive days. Additionally, CMS has provided new guidance regarding the length of time required for Medicaid eligibility and has revised the eligibility time frame from 30 days to 1 day.

Insure Oklahoma rules are revised to provide clarification in regard to carrier and health plan rate structure requirements. Carriers and health plans must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a carrier and/or health plan can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the carrier and/or health plan will not be allowed to participate in the Insure Oklahoma program. Carrier and/or health plan rate structure requirements include all rate tiers and age-up methodologies.

Original signed on 12-21-10

Mary Stalnaker, Director
Family Support Services Division

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WF # 10-DD (NAP)

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 an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS 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, OKDHS 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, OKDHS: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 405-521-4326.

<u>REMOVE</u>	<u>INSERT</u>
317:2-1-2	317:2-1-2, pages 1-3, revised 11-15-10
317:2-1-5	317:2-1-5, pages 1-2, revised 11-15-10
317:2-1-6	317:2-1-6, 1 page only, revised 11-15-10
317:2-1-7	317:2-1-7, pages 1-3, revised 11-15-10
317:2-1-13	317:2-1-13, 1 page only, revised 11-15-10
317:30-3-28	317:30-3-28, pages 1-4, revised 11-15-10
317:30-5-72.1	317:30-5-72.1, pages 1-2, revised 11-15-10
317:30-5-77	317:30-5-77, 1 page only, revised 11-15-10
317:30-5-78	317:30-5-78, pages 1-3, revised 11-15-10
317:30-5-78.1	317:30-5-78.1, 1 page only, revised 11-15-10
317:35-5-25	317:35-5-25, pages 1-9, revised 11-15-10
317:35-23-2	317:35-23-2, 1 page only, revised 11-15-10
-----	317:45-3-3, 1 page only, issued 11-15-10
-----	317:45-5-3, 1 page only, issued 11-15-10

317:2-1-2. Appeals**(a) Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 C.F.R. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) Provider Process Overview.

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in 317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files a

grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(E) Unless an exception is provided in 317:2-1-13, the Administrative Law Judge's decision is appealable to OHCA's CEO under 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(F) Proposed administrative sanction appeals pursuant to 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(G) Appeals which relate to eligibility determinations made by OHCA;

(H) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review

- (PASRR) was completed as required by law;
- (B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
- (C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
- (D) Petitions for Rulemaking;
- (E) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;
- (F) Drug rebate appeals;
- (G) Nursing home contracts which are terminated, denied, or non-renewed;
- (H) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;
- (I) Contract award appeals;
- (J) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and
- (K) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives.

317:2-1-5. Hearing procedures

(a) Hearings will be conducted in an informal manner without formal rules of evidence or procedure, except for hearings under 317:2-1-7.

(b) No party is required to be represented by an attorney. Members may represent themselves or authorize another party to represent them. A person or entity desiring to represent a member must provide documentation of the consent of the member to be represented by that person or entity. An appeal will be rejected without documentation of representation. Individuals appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.

(c) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.

(d) The OHCA Administrative Law Judge or designee may:

(1) Rule on any requests for extension of time;

(2) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

(3) Require the parties to state their positions concerning the various issues in the proceeding;

(4) Require the parties to produce for examination those relevant witnesses and documents under their control;

(5) Rule on motions and other procedural items;

(6) Regulate the course of the hearing and conduct of the participants;

(7) Establish time limits for the submission of motions or memoranda;

(8) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

(A) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(B) Excluding all testimony of an unresponsive or evasive witness; or

(C) Expelling the person from further participation in the hearing;

(9) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(10) Administer oaths or affirmations;

(11) Determine the location of the hearing;

(12) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting

party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(13) Recess and reconvene the hearing;

(14) Set and/or limit the time frame of the hearing;

(15) Reconsider or rehear a matter for good cause shown; and

(16) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

(e) The burden of proof during the hearing will be upon the appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(f) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

(g) In any case in which a member requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.

(h) An appeal, or an issue addressed by an appeal, may be dismissed if:

(1) it is moot or there is insufficient evidence to support the allegations;

(2) the appellant fails or refuses to appear for a scheduled meeting;

(3) the appellant refuses to accept a settlement offer which affords the relief he or she could reasonably expect if he or she prevailed in the appeal; or

(4) it is not timely filed or is not within the OHCA's jurisdiction or authority.

317:2-1-6. Other grievance procedures and processes

Other grievance procedures and processes include those set out in 317:2-1-7 (Provider Appeals of OHCA Audit Findings); 317:2-1-8 (Nursing Home Provider Contract Appeals); 317:2-1-9 (OHCA's Designated Agent's Appeal Process for QIO Services); 317:2-1-10 (Drug Rebate Appeal Process); 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process); and 317:2-1-14 (Contract Award Protest Process).

317:2-1-7. Oklahoma Health Care Authority Audit

All appeals related to audits and/or reviews resulting in overpayments are heard by an OHCA Administrative Law Judge.

(1) If a provider disagrees with a decision of an OHCA audit, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision by submitting an LD-2 form to OHCA's docket clerk.

(2) The appeal will be commenced by the receipt of an LD-2 form from the appellant provider. The form must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The provider should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. All relevant exhibits the provider believes necessary to decide the appeal should be attached to the LD-2 form, including the following:

(A) Citations for any statute or rule that the provider feels has been violated;

(B) The provider's name, address and telephone number;

(C) The name, address, and phone number of the provider's representative, if any; and

(D) The LD-2 must be signed by the provider or provider's representative.

(3) Upon receipt of the appeal by the docket clerk, the matter will be docketed for a hearing before an OHCA Administrative Law Judge.

(4) Any change in contact information during the course of the appeal should be immediately reported to the OHCA docket clerk.

(5) The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.

(6) Within 45 days of the LD-2 being received and filed by the OHCA, any settlement discussions being held by the parties must be finalized. Settlement or mediation of audit disputes is encouraged and can begin at any time of the audit process between the provider and OHCA's Legal Division. If settlement is reached, the terms shall be set out in writing and signed by both parties and/or their representatives. Upon the finalization and signature of the settlement agreement, the appeal(s) shall be dismissed.

(7) Audit appeals which are not settled will commence with a prehearing conference before the assigned administrative law judge as follows:

(A) At the conference the parties shall clarify and isolate

the legal and factual issues involved in the audit appeal.

(B) Each party shall be present, on time and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown.

(C) Prior to the prehearing conference each party shall file with the OHCA and provide a copy to the other party:

(i) A brief statement of his or her case, to include a list of stipulations and legal and factual issues to be heard;

(ii) A list of any witnesses who have direct knowledge of the facts surrounding the issues of the appeal and who are expected to be called at the hearing. The list shall include a brief statement of the testimony each witness will offer;

(iii) A list of any documents and exhibits and the original or a copy of each document or exhibit to be offered into evidence or presented at the hearing; and

(iv) Any requirements or requests for discovery.

(D) Administrative Law Judge shall:

(i) hear and rule on pending requests or motions;

(ii) rule on whether or not witnesses have knowledge of the facts at issue;

(iii) rule on whether or not documents and exhibits are relevant;

(iv) rule on whether or not discovery requests and other motions and requests are relevant;

(v) strike or deny witnesses, documents, exhibits, discovery requests and other requests or motions which are cumulative, not relevant or not material, used as a means of harassment, unduly burdensome or not timely filed; and

(vi) identify and rule on errors being appealed and issues to be heard at the administrative hearing.

(E) The prehearing conference shall be informal, structured by the administrative law judge and not open to the public. The administrative law judge shall record the prehearing conference by digital recording.

(i) Each party shall be notified of the date of the prehearing conference at least 10 calendar days prior to the scheduled prehearing conference.

(ii) Witnesses shall not appear or present testimony at the prehearing conference.

(F) A request for continuance of a prehearing conference can be made up to three days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The administrative judge shall rule on the request and in no case shall a combination of

continuances exceed a total of 30 calendar days except for good cause shown.

(G) The administrative judge shall issue a prehearing conference statement setting out the witnesses, exhibits, documents and issues to be presented at the hearing; the hearing date; the decisions reviewed and made during the prehearing conference and any stipulations agreed to by the parties.

(8) The hearing shall be digitally recorded and closed to the public.

(9) The administrative law judge should attempt to make the final hearing decision within 180 days from the date of the prehearing conference. The final order shall be the entire record of the appeal. Pursuant to Administrative Procedures Act, the Order does not need to contain findings of fact or conclusions of law. The final order is the final decision and is not appealable to the CEO.

317:2-1-13. Appeal to the Chief Executive Officer

(a) The Oklahoma Health Care Authority offers approximately 40 different types of administrative appeals. Some of the appeals are appealable to the Chief Executive Officer, and some are not. The following appeals may be heard by the Chief Executive Officer:

(1) Appeals under 317:2-1-2(c)(1)(A) to (c)(1)(H), with the exception of Subsection (F);

(2) Appeals under 317:2-1-2(c)(2)(A) to (c)(2)(K), with the exceptions of Subsections (H) and (J); and

(3) Appeals under 317:2-1-8 and 317:2-1-10.

(b) Appeals to the Chief Executive Officer must be filed with the OHCA within twenty (20) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the Chief Executive Officer.

(d) Appeals to the Chief Executive Officer under (a) of this Section may be filed by the provider, member, or agency. The Chief Executive Officer will ordinarily render decisions within sixty (60) days of the receipt of the appeal.

317:30-3-28. Electronic Health Records Incentive Program

(a) **Program.** The Oklahoma Electronic Health Records Incentive Program is authorized by the American Recovery and Reinvestment Act of 2009. Under this program, SoonerCare providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade, or meaningfully use certified electronic health records (EHR) technology. The EHR incentive program is governed by the policy in this section and the Electronic Health Records Program Final Rule issued by CMS in CMS-0033-F and 45 CFR 170. Providers should also use the EHR program manual as a reference for additional program details.

(b) **Eligible providers.** To qualify for incentive payments, a provider must be an "eligible professional" or an "eligible hospital." Providers who receive incentive payments must have an existing Provider Agreement with OHCA and at least one of their facilities must be located within the State of Oklahoma.

(1) **Eligible professionals.** An eligible professional is defined as a physician, a physician assistant practicing in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) led by a physician assistant, a board certified pediatrician, a nurse practitioner, a certified nurse midwife, or a dentist. OHCA will determine eligibility based on the provider type, specialty associated with the provider in the MMIS system, and documentation.

(A) Eligible professionals may not be hospital-based, unless they practice predominantly at an FQHC or RHC as defined by the CMS Final Rule. A "hospital-based" professional furnishes ninety percent (90%) or more of their SoonerCare-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or Emergency Room, through the use of the facilities and equipment of the hospital.

(B) Eligible professionals may not participate in both the Medicaid and Medicare EHR incentive payment program during the same payment year.

(2) **Eligible hospitals.** Eligible hospitals are Children's Hospitals or Acute Care Hospitals, including Critical Access Hospitals and cancer hospitals. An Acute Care Hospital is defined as a health care facility where the average length of patient stay is twenty-five (25) days or fewer and that has a CMS certification number that has the last four digits in the series 0001-0879 and 1300-1399. A Children's Hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly

treats individuals under 21 years of age and has a CMS certification number with the last 4 digits in the series 3300-3399. Hospitals that do not meet either of the preceding definitions are not eligible for incentive payments.

(c) **Patient volume.** Eligible professionals and eligible hospitals must meet SoonerCare patient volume criteria to qualify for incentive payments. Patient volume criteria compliance will be verified by the OHCA through claims data and provider audits. When calculating SoonerCare patient volume, all SoonerCare populations may be counted. To calculate patient volume, the provider's total SoonerCare patient encounters in the specified reporting period must be divided by the provider's total patient encounters in the same reporting period.

(1) **Eligible professionals.** Eligible professionals must meet a 30% SoonerCare patient volume threshold over a continuous 90-day period in the preceding calendar year. The only exception is for pediatricians, as discussed in OAC 317:30-3-28(c)(5).

(2) **Eligible hospitals.** With the exception of children's hospitals, which have no patient volume requirement, eligible hospitals must meet a 10% SoonerCare patient volume threshold over a continuous 90-day period in the preceding calendar year.

(3) **FQHC or RHC patient volume.** Eligible professionals practicing predominantly in an FQHC or RHC may be evaluated according to their "needy individual" patient volume. To qualify as a "needy individual," patients must meet one of the following criteria:

(A) Received medical assistance from SoonerCare;

(B) Were furnished uncompensated care by the provider; or

(C) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

(4) **Clinics and group practices.** Clinics or group practices may calculate patient volume using the clinic's or group's SoonerCare patient volume under the following conditions:

(A) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

(B) There is an auditable data source to support the patient volume determination;

(C) All eligible professionals in the clinic or group practice use the same methodology for the payment year;

(D) The clinic or group practice uses the entire practice's patient volume and does not limit patient volume in any way; and

(E) If an eligible professional works inside and outside of the clinic or practice, the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional's outside encounters.

(5) **Pediatricians.** Pediatricians may qualify for 2/3 incentive payments if their SoonerCare patient volume is 20-29%. A pediatrician is defined as a medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children and possesses a valid, unrestricted medical license and board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP). To qualify as a pediatrician for the purpose of receiving a 2/3 payment under the incentive program, the provider must provide OHCA with a copy of their pediatric licenses and board certification.

(6) **Out of state patients.** For eligible professionals and eligible hospitals using out of state Medicaid recipients for patient volume requirement purposes, the provider must retain proof of the encounter for the out of state patient.

(d) **Attestation.** Eligible professionals and eligible hospitals must execute an amendment to their SoonerCare Provider Agreement to attest to meeting program criteria through the Electronic Provider Enrollment (EPE) system in order to qualify for incentive payments.

Registration in the CMS EHR Incentive Payment Registration and Attestation system is a pre-requisite to EPE attestation.

(e) **Adoption/ Implementation/ Upgrade (A/I/U).** Eligible professionals or eligible hospitals in their first participation year under the Oklahoma EHR Incentive Payment Program may choose to attest to adopting, implementing, or upgrading certified EHR technology. Proof of A/I/U must be submitted to OHCA in order to receive payment.

(f) **Meaningful use.** Eligible professionals in their second through sixth participation year and eligible hospitals in their second through third participation year must attest to meaningful use of certified EHR technology. Eligible hospitals must attest to meaningful use if they are participating in both the Medicare and Oklahoma EHR Incentive Programs in their first participation year.

The definition of "meaningful use" is outlined in, and determined by, the Electronic Health Records Program Final Rule CMS-0033-F.

(g) **Payment.** Eligible professionals may receive a maximum of \$63,750 in incentive payments over six years. Providers must begin their participation by 2016 to be eligible for payments. Payments will be made one time per year per provider and will be available

through 2021. Eligible hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016.

(1) Eligible professionals and eligible hospitals must use a Taxpayer Identification Number (TIN) to assign a valid entity as the incentive payments recipient. Valid entities may be the individual provider or a group with which the provider is associated. The assigned payee must have a current Provider Agreement with OHCA.

(2) The provider is responsible for repayment of any identified overpayment. In the event OHCA determines monies have been paid inappropriately, OHCA will recoup the funds by reducing any future payments owed to the provider.

(h) **Administrative appeals.** Administrative appeals of decisions related to the Oklahoma Electronic Health Records Incentive Program will be handled under the procedures described in OAC 317:2-1-2(b).

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

- (A) Agents used to promote fertility.
- (B) Agents primarily used to promote hair growth.
- (C) Agents used for cosmetic purposes.
- (D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.
- (E) Agents that are experimental or whose side effects make usage controversial.
- (F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(2) The drug categories listed in (A) through (E) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

- (i) prenatal vitamins are covered for pregnant women up to age 50;
- (ii) fluoride preparations are covered for persons under 16 years of age or pregnant;
- (iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered;
- (iv) iron supplements may be covered for pregnant women if determined to be medically necessary; and
- (v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol.

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

(D) Coverage of non-prescription or over the counter drugs is limited to:

- (i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;
- (ii) certain smoking cessation products;
- (iii) family planning products;
- (iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate; and
- (v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(E) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

- (A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. ' 1396r-8; or
- (B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-77. Brand necessary certification

(a) When a product is available in both a brand and generic form, a prior authorization is required before the branded product may be dispensed. The prescribing provider must certify the brand name drug product is medically necessary for the well being of the patient, otherwise a generic must be substituted for the name brand product.

(1) The certification must be written in the physician's or other prescribing provider's handwriting.

(2) Certification must be written directly on the prescription blank or on a separate sheet which is attached to the original prescription.

(3) A standard phrase indicating the need for a specific brand is required. The OHCA recommends use of the phrase "Brand Necessary".

(4) It is unacceptable to use a printed box on the prescription blank that could be checked by the physician to indicate brand necessary, or to use a hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription blank.

(5) If a physician phones a prescription to the pharmacy and indicates the need for a specific brand, the physician should be informed of the need for a handwritten certification. The pharmacy can either request that the certification document be given to the patient who then delivers it to the pharmacy upon receipt of the prescription, or request the physician send the certification through the mail.

(b) The Brand Necessary Certification applies to CMS Federal Upper Limit and State Maximum Allowable Cost (SMAC) products.

(c) For certain narrow therapeutic index drugs, a prior authorization will not be required. The DUR Board will select and maintain the list of narrow therapeutic index drugs.

(d) Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) facilities are exempt from prior authorization requirements for brand name drugs.

317:30-5-78. Reimbursement

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of an estimate of the ingredient cost, plus a dispensing fee.

(b) **Ingredient Cost.** Ingredient cost is estimated by one of the following methods:

(1) **Maximum Allowable Cost.**

(A) The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing invoices that reflect a net cost higher than the calculated SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.

(B) The Federal Upper Limit (FUL) is established by CMS in accordance with applicable federal laws and regulations.

(C) Injectable drugs which are dispensed by a retail pharmacy through the Vendor Drug Program shall be priced based on a formula equivalent to the Medicare allowed charge whether they are furnished through the pharmacy program or through the medical program.

(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage.

The current benchmark price is the Average Wholesale Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%.

(c) **Maximum allowable dispensing fee.** The maximum allowable dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) **Reimbursement for prescription claims.** Prescription claims

will be reimbursed using the lower of the following calculation methods:

(1) the lower of estimated acquisition cost, Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) plus a dispensing fee, or

(2) usual and customary charge to the general public. The pharmacy is responsible to determine its usual and customary charge to the general public. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

- (1) have an existing provider agreement with OHCA,
- (2) submit the claim in a format acceptable to OHCA,
- (3) have a prior authorization before filling the prescription, if a prior authorization is necessary,
- (4) have a proper brand name certification for the drug, if necessary, and
- (5) include the usual and customary charges to the general public as well as the estimated acquisition cost and dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be

accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

317:30-5-78.1. Special billing procedures

(a) **Antihemophiliac Factor (AHF) Products.** AHF products are sold by the amount of drug (International Units of AHF) in the container. For their products, regardless of the container size, the package size is always "1". Therefore, pricing assumes that the "package size" actually dispensed is the actual number of units dispensed. Examples: If 250 AHF units are dispensed and multiplied by a unit cost of \$.25, the allowable cost would be \$62.50. Metric Quantity is shown as 250; if 500 AHF units are dispensed and multiplied by a unit cost of \$.25, the allowable would be \$125.00. Metric Quantity is shown as 500.

(b) **Compound and intravenous drugs.** Prescriptions claims for compound and Intravenous (IV) drugs are billed and reimbursed using the NDC number and quantity for each compensable ingredient in the compound or IV, up to 25 ingredients. Ingredients without an NDC number are not compensable. A dispensing fee as described in OAC 317:30-5-78(c) is added to the total ingredient cost.

(c) **Co-Payment.** Pharmacies must pursue all third party resources before filing a claim with OHCA as set out in 42 CFR 433.139.

(d) **Over-the-counter drugs.** Payment for covered over-the-counter medication is made according to the reimbursement methodology in OAC 317:30-5-78(d).

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services. The appropriate Durable Medical Equipment Regional Carrier (DMERC) must be billed prior to billing OHCA for all Medicare compensable drugs.

Part B crossover claims cannot be submitted through the pharmacy point of sale system and must be submitted using the CMS 1500 form or electronic equivalent.

(f) **Claims for prescriptions which are not picked up.** A prescription for a member which has been submitted to and approved for payment by OHCA which has not been received by the member within 15 days of the date of service must be reversed. An electronic reversal will cause a refund to be generated to the agency. Claims may also be reversed using a manual process if electronic reversal is not possible. For the purpose of this Section, the date of service means the date the prescription was filled.

(g) **Non-prescription products.** The coverage of non-prescription products that are determined to be medically necessary must be billed through the pharmacy point of sale system.

317:35-5-25. Citizenship/alien status and identity verification requirements

(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport; ■ 1

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS) (Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; ■ 2 or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

■ 3

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

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- (iii) A U.S. Citizen ID Card (Form I-179 or I-197);
 - (iv) A Northern Mariana Identification Card (Form I-873) (Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);
 - (v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);
 - (vi) A Final Adoption Decree showing the child's name and U. S. place of birth;
 - (vii) Evidence of U.S. Civil Service employment before 6/1/1976;
 - (viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);
 - (ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;
 - (x) Oklahoma Voter Registration Card; or
 - (xi) Other acceptable documentation as approved by OHCA.
- (B) Other less reliable forms of citizenship verification are:
- (i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;
 - (ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;
 - (iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
 - (iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for SoonerCare. This evidence must be one of the following and show a U.S. place of birth:
 - (I) Seneca Indian tribal census record;
 - (II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
 - (III) U.S. State Vital Statistics official notification of birth registration;
 - (IV) An amended U.S. public birth record that is

amended more than five years after the person's birth;
or

(V) Statement signed by the physician or midwife who
was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany
citizenship evidence listed in (A) and (B) of paragraph (2) of
this subsection includes:

(A) A driver's license issued by a U.S. state or territory
with either a photograph of the individual or other
identifying information such as name, age, sex, race, height,
weight, or eye color;

(B) A school identification card with a photograph of the
individual;

(C) An identification card issued by Federal, state, or local
government with the same information included on driver's
licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate
of Degree of Indian Blood, or other U.S. American
Indian/Alaska Native Tribal document with a photograph of the
individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as
reported by the OKDHS;

(I) For children under 16, school records may include nursery
or daycare records;

(J) If none of the verification items on the list are
available, an affidavit may be used for children under 16.
An affidavit is only acceptable if it is signed under penalty
of perjury by a parent or guardian stating the date and place
of the birth of the child and cannot be used if an affidavit
for citizenship was provided.

(b) **Reasonable opportunity to obtain citizenship verification.** ■ 4

(1) When the applicant/member is unable to obtain citizenship
verification, a reasonable opportunity is afforded the
applicant/member to obtain the evidence as well as assistance in
doing so. A reasonable opportunity is afforded the
applicant/member before taking action affecting the individual's
eligibility for SoonerCare. The reasonable opportunity time
frame usually consists of 60 days. In rare instances, the time
frame may be extended to a period not to exceed an additional 60
days.

(2) The following methods of verification are the least reliable

forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates a U.S. place of birth. For children under 16, the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim or citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements.** SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility. ■ 5

(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of SoonerCare services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five years from the date of entry and who was:

- (i) lawfully admitted for permanent residence under the Immigration and Nationality Act;
- (ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;
- (iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or
- (iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:

- (i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;
- (ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;
- (iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;
- (iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;
- (v) an alien who is a veteran as defined in 38 U.S.C. ' 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;
- (vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;
- (vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph;
- (viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or
- (ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

(2) Other aliens lawfully admitted for permanent residence (non-qualified aliens). Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any

of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for SoonerCare for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Iraqi special immigrants are considered lawful permanent residents.

(5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(6) **Ineligible aliens.**

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully

admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record - Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.

(7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the BCIS. These are individuals who entered this country with the express intention of residing here permanently.

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes.

These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by BCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in *Silva vs. Levi*, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section. ■ 6

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. This does not include the non-citizen whose membership

in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by BCIS. They are eligible for emergency services only.

INSTRUCTIONS TO STAFF

1. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. **NOTE:** spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. **EXCEPTION:** Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.
2. Medicare and SSI recipients do not have to verify their citizenship and identity as they have previously been verified by SSA.
3. Verification should be placed in the case file and documented in case notes.
4. Designated OKDHS staff will have access to the OSDH web based verification system to verify record of Oklahoma birth. The birth record document must have been issued before the person was five years of age.
5. See OKDHS Appendix J, Citizenship and Alienage.
6. Verification issued by the Department of Homeland Security will identify U.S. citizen members of the Texas Band of Kickapoo Indians living near the U.S./Mexican border.

317:35-23-2. Eligibility criteria

Adults with disabilities or long-term illnesses, members with mental retardation and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

317:45-3-3. Carrier rate structure requirements

Carriers must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a carrier can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the carrier will not be allowed to participate in the Insure Oklahoma program and all health plans submitted by the carrier for participation in the Insure Oklahoma program as a qualified health plan will not be considered. Carrier rate structure requirements include all rate tiers and age-up methodologies.

317:45-5-3. Health plan rate structure requirements

Health plans must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a health plan can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the health plan will not be allowed to participate in the Insure Oklahoma program. Health plan rate structure requirements include all rate tiers and age-up methodologies.