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POLICY TRANSMITTAL NO. 05-38	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 317:35-5-2; 35-5-8; 35-7-37; 35-7-48; 35-7-60; and 35-7-60.1.

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

Rules are revised to establish program guidelines for a new federally approved Family Planning Waiver program. Medicaid eligibility is expanded to provide family planning benefits to Oklahoma women, men and couples who are ages 19 and older, with family incomes at or below 185% of the Federal Poverty Level, who are not otherwise eligible for Medicaid and who do not have creditable health insurance coverage.

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-R (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**

317:35-5-2

317:35-5-2, pages 1-2, revised 4-1-05

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317:35-5-8, 1 page only, issued 4-1-05

317:35-7-37

317:35-7-37, pages 1-2, revised 4-1-05

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317:35-7-48, 1 page only, issued 4-1-05

317:35-7-60

317:35-7-60, pages 1-5, revised 4-1-05

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317:35-7-60.1, 1 page only, issued 4-1-05

**317:35-5-2. Categorically related programs**

(a) Categorical relationship is established using the same definitions of age, disability and blindness as are used by the Social Security Administration (SSA) in determining eligibility for Supplemental Security Income (SSI) or SSA benefits. If the individual is a SSA/SSI recipient in current payment status (including presumptive eligibility), a TANF recipient, or is under age 19, categorical relationship is automatically established. Categorical relationship to pregnancy-related services is established when the determination is made by medical evidence that the individual is or has been pregnant. Pregnancy-related services include all medical services provided within the scope of the program during the prenatal, delivery and post-partum periods. For an individual age 19 or over to be related to AFDC, the individual must have a minor dependent child who is deprived of parental support. Categorical relationship to Refugee services is established in accordance with OAC 317:35-5-25. Categorical relationship for the Breast and Cervical Cancer Treatment program is established in accordance with OAC 317:35-21. Categorical relationship for the Family Planning Waiver Program is established in accordance with OAC 317:35-5-8. To be eligible for Medicaid benefits, an individual must be related to one of the following:

- (1) Aged
- (2) Disabled
- (3) Blind
- (4) Pregnancy
- (5) Aid to Families With Dependent Children
- (6) Refugee
- (7) Breast and Cervical Cancer Treatment program
- (8) Family Planning Waiver Program

(b) The Authority may provide Medicaid to reasonable categories of individuals under age 21 who are not receiving cash assistance under any program but who meet the income requirement of the State's approved AFDC plan. Individuals eligible for Medicaid benefits include individuals between the ages of 19 and 21:

(1) for whom a public agency is assuming full or partial financial responsibility who are in the custody of the State as reported by the Oklahoma Department of Human Services and in foster homes, private institutions or public facilities; or

(2) in adoptions subsidized in full or in part by a public agency; or

(3) individuals under age 21 receiving active treatment as inpatients in public psychiatric facilities or programs if inpatient psychiatric services for individuals under age 21 are provided under the State Plan and the individuals are supported in full or in part by a public agency.

317:35-5-8. Determining categorical relationship for the Family  
Planning Waiver Program

All uninsured women and men ages 19 and older, regardless of pregnancy or paternity history, with family income at or below 185% of the federal poverty level and who are otherwise ineligible for Medicaid benefits are categorically related to the Family Planning Waiver Program.



**317:35-7-37. Financial eligibility of individuals categorically related to AFDC, pregnancy-related services or Family Planning Waiver Program**

(a) **AFDC and/or pregnancy-related services.**

(1) In determining financial eligibility for an individual related to AFDC or pregnancy-related services, the income of the following persons (if living together or if living apart as long as there has been no break in the family relationship) are considered. These persons include:

(A) the individual;

(B) the spouse of the individual;

(C) the biological or adoptive parent(s) of the individual who is a minor dependent child. Income of the stepparent of the minor dependent child is determined according to OAC 35-10-26(a)(8);

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

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

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

(2) The family has the option to exclude minor dependent children or blood related siblings OAC 317:35-7-37(1)(D) and (E) and their income from the eligibility process. However, for the adult to be eligible, at least one minor child and his/her income [see OAC 317:35-7-37(a)(4)] must be included in the case. The worker has the responsibility to inform the family of the most advantageous consideration in regard to coverage and income. When determining financial eligibility for an individual related to AFDC or pregnancy-related services,

consideration is not given to income of any person who is aged, blind or disabled and is determined to be categorically needy.

(3) An individual categorized as aged, blind, or disabled who is not an SSI recipient has an option to be categorically related to either AFDC or ABD. The individual may be included in the AFDC related benefit group pending determination of eligibility for ABD or SSI if all eligibility requirements are met. ■ 1

(4) An individual who receives SSI cannot be included in the AFDC related benefit group. When the only dependent child is receiving SSI, the natural or adoptive parent(s) or caretaker relative may be related to AFDC if all other factors of eligibility are met. The benefit group will consist of the adult(s) only. Applicants and recipients are informed of their responsibility to report to the OKDHS if any member of the benefit group makes application for SSI or becomes eligible for SSI.

(b) Family Planning Waiver Program. In determining financial eligibility for the FPW program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. The worker has the responsibility to inform the individual of the most advantageous consideration in regard to coverage and income.

**INSTRUCTIONS TO STAFF**

1. The worker is responsible for explaining the benefits of both programs but the recipient is responsible for choosing the program that is most beneficial in meeting the individual's needs.

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

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

(1) The income is at or below 185% of the federal poverty level.

(2) The individual is not otherwise eligible for Medicaid.

(3) The individual is uninsured or has health insurance coverage but this coverage excludes all coverage for family planning services.

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

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

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



**317:35-7-60. Certification for Medical Services**

(a) The rules in this Section apply to all categories of eligibles  
**EXCEPT:**

(1) categorically needy SoonerCare Health Benefit recipients who are categorically related to AFDC or Pregnancy Related Services,  
AND

(2) who if eligible, would be enrolled in SoonerCare, or

(3) individuals categorically related to the Family Planning Waiver Program.

(b) An individual determined eligible for Medical Services may be certified for a medical service provided on or after the first day of the third month prior to the month of application. The certification period is determined beginning with the month the medical service was received or expected to be received or the month of application for categorically needy cases in which a medical service has not been received. The period of certification may cover retroactive or future months. Assignment of the certification period is dependent on the categorical relationship. Form MA-2, Medical Assistance Computation Work Sheet, is used to determine the certification period. The certification period in family cases is assigned for the shortest period of eligibility determined for any individual in the case.

(1) **Certification as categorically needy.** A categorically needy individual who is categorically related to ABD is assigned a certification period of 12 months. A categorically needy individual who is determined eligible for a State Supplemental Payment (SSP) is certified effective the month of application. If the individual is also eligible for payment for medical services received during the three months preceding the month of application, the Medicaid benefit is certified for the appropriate months. If the individual is not eligible for SSP the first month of certification is the month that a medical service was provided or, if no medical service was provided, the month of application.

(A) **Certification of individuals categorically needy and categorically related to ABD.** The certification period for the individual categorically related to ABD can be assigned

for up to 12 months. The individual must be determined as categorically needy for each month of the certification period. The certification period is 12 months unless the individual:

- (i) is certified as eligible in a money payment case during the 12 month period;
- (ii) is certified for long-term care during the 12 month period;
- (iii) becomes ineligible for medical assistance after the initial month;
- (iv) becomes ineligible as categorically needy; or
- (v) is deceased.

(B) **Certification period.** If any of the situations listed in subparagraph (A) of this paragraph occur after the initial month, the case is closed by the worker.

- (i) If income and/or resources change after certification causing the case to exceed the categorically needy maximums, the case is closed.
- (ii) A pregnant individual included in an ABD case which closes continues to be eligible for pregnancy related services through the postpartum period.

(2) **Certification of individuals categorically related to ABD and eligible as Qualified Medicare Beneficiaries Plus.** The Medicaid benefit may be certified on the first day of the third month prior to the month of application or later. If the individual receives Medicare and is eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the month of certification for SSP. If the individual receives Medicare and is not eligible for SSP, the effective date of certification for the Medicare Part B premium buy-in is the first day of the month following the month in which the eligibility determination is made (regardless of when application was made).

(A) An individual determined eligible for QMBP benefits is

assigned a certification period of 12 months. At any time during the certification period that the individual becomes ineligible, the case is closed using regular negative action procedures.

(B) At the end of the certification period a redetermination of QMBP eligibility is required, using the same forms and procedures as for ABD categorically needy individuals.

(3) **Certification of individuals categorically related to ABD and eligible as Qualified Disabled and Working Individual.** The Social Security Administration is responsible for referrals of individuals potentially eligible for QDWI. Eligibility factors verified by the SSA are Medicare Part A eligibility and discontinuation of disability benefits due to excessive earnings. When the OKDHS State Office receives referrals from SSA the county will be notified and is responsible for obtaining an application and establishing other factors of eligibility. If an individual contacts the county office stating he/she has been advised by SSA that they are a potential QDWI, the county takes a Medicaid application. If the individual does not have verification of eligibility factors determined by SSA, the county contacts OKDHS, FSSD, State Office, for assistance in verifying those factors. The verification will be obtained by OKDHS State Office and sent to the county office. The effective date of certification for QDWI benefits is based on the date of application and the date all eligibility criteria, including enrollment for Medicare Part A, are met. For example, if an individual applies for benefits in October and is already enrolled in Medicare Part A, eligibility can be effective October 1 (or up to three months prior to October 1, if all eligibility criteria are met during the three month period). However, if in the example, the individual's enrollment for Part A is not effective until November 1, eligibility cannot be effective until that date. Eligibility can never be effective prior to July 1, 1990, the effective date of this provision. These cases will be certified for a period of 12 months. At the end of the 12-month period, eligibility redetermination is required. If the individual becomes ineligible at any time during the certification period, the case is closed. The reason for closure is 69, and the worker completes the Notice to Client form.

(4) **Certification of individuals categorically related to ABD**

and eligible as **Specified Low-Income Medicare Beneficiary (SLMB)**. The effective date of certification of SLMB benefits may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for SLMB benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period a redetermination of SLMB eligibility is required. A redetermination of SLMB eligibility must also be done at the same time a dually eligible individual has a redetermination of eligibility for other Medicaid benefits such as long-term care.

**(5) Certification of individuals categorically related to disability and eligible for TB related services.**

(A) An individual determined eligible for TB related services may be certified the first day of the third month prior to the month of application or later, as long as verification is received of a diagnosis of TB infection.

(B) A certification period of 12 months will be assigned. At any time during the certification period that the individual becomes ineligible, the case is closed using the regular negative action procedures.

(C) At the end of the certification period a new application will be required if additional treatment is needed.

**(6) Certification of individuals categorically related to ABD and eligible as **Qualifying Individuals**.** The effective date of certification for the QI-1 may begin on the first day of the third month prior to the month of application or later. A certification can never be earlier than the date of entitlement of Medicare Part A. An individual determined eligible for QI benefits is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of QI eligibility is required.

(A) Since the State's allotment to pay Medicare premiums for this group of individuals is limited, the State must limit the number of QIs so that the amount of assistance provided during the year does not exceed the State's allotment for that year.

(B) Persons selected to receive assistance are entitled to receive assistance with their Medicare premiums for the remainder of the federal fiscal year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year.



317:35-7-60.1. Certification for the Family Planning Waiver Program.

The effective date of certification for the Family Planning Waiver Program is the first day of the month of application or later. An individual determined eligible for the Family Planning Waiver Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.