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POLICY TRANSMITTAL NO. 05-26	DATE: APRIL 27, 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 317:30-3-2.1; 30-5-96; 30-5-134; 30-5-907 through 30-5-907.3;  
and 35-6-64.1.

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

Medical Providers-Fee for Service rules are revised to allow for the use of extrapolation when calculating provider overpayment.

Inpatient Psychiatric Hospitals specific, rules are revised to change the reimbursement methodology for state owned Residential Treatment Centers.

Long Term Care Facilities rules are revised to establish maximum reimbursement for Nurse Aide Training costs and to allow the payment to be made in the daily per diem rate paid the nursing facility if the nurse aid is trained and tested in that Medicaid contracted nursing facility's training program.

Rules are issued to establish reimbursement criteria for diagnostic procedures performed by Independent Diagnostic Testing Facilities and Mobile X-Ray entities.

Eligibility rules are issued to comply with federal regulations by establishing guidelines that implement Transitional Medical Assistance (TMA). These rules provide continued Medical Assistance to a Medicaid Only benefit group who loses eligibility due to the receipt of new or increased child or spousal support, or new or increased earnings of the caretaker relative.

Original signed on April 26, 2005

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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 # 04-J (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**

317:30-3-2.1	317:30-3-2.1, pages 1-3, issued 10-6-04
317:30-5-96	317:30-5-96, pages 1-7, revised 12-1-04
317:30-5-134	317:30-5-134, pages 1-2, revised 11-1-04
-----	317:30-5-907, 1 page only, issued 10-6-04
-----	317:30-5-907.1, 1 page only, issued 10-6-04
-----	317:30-5-907.2, 1 page only, issued 10-6-04
-----	317:30-5-907.3, 1 page only, issued 10-6-04
317:35-6-64.1	317:35-6-64.1, pages 1-7, issued 5-1-04

317:30-3-2.1. Program Integrity Audits/Reviews

(a) This section applies to all contractors/providers:

(1) "Contractor/provider" means any person or organization that has signed a provider agreement with OHCA.

(2) "Extrapolation" means the methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of a probability sample to the universe from which the sample was drawn.

(3) "Probability sample" means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(b) An OHCA audit/review includes the following:

(1) An examination of provider records, by either an on-site or desk audit. Claims may be examined for compliance with relevant federal and state laws and regulations, written provider billing instructions, numbered memoranda, and/or medical necessity.

(2) A draft audit/initial review report, which contains preliminary findings.

(3) An informal reconsideration period in which the provider may supply relevant information to clear any misunderstandings and/or findings.

(4) The right to a formal appeal, if the contractor/provider requests it.

(5) A final audit/review report.

(c) When OHCA conducts a probability sample audit, the sample claims are selected on the basis of recognized and generally accepted sampling methods. If sampling reveals patterns of inappropriate coding, failure to adhere to Medicaid policies, issues related to medical necessity, consistent patterns of overcharging, lack of appropriate documentation, or other fiscal abuse of the Medicaid program, with an error rate of more than 10%, the provider may be required to reimburse OHCA the extrapolated amount.

(1) When projecting the overpayment, using statistical sampling, OHCA uses a sample that is sufficient to ensure a minimum 95% confidence level.

(2) When calculating the amount to be recovered, OHCA ensures that all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn.

(3) OHCA does not consider non-billed services or supplies when calculating underpayments and overpayments.

(d) If sampling reveals an error rate of 10% or less, the provider will be required to reimburse OHCA for any overpayments noted during the review.

(e) In those instances when the probability sample results in an error rate in excess of 10%, the results of a probability sample may be used by OHCA to extrapolate the amount to be recovered.

(f) Burden of Proof. When the provider disagrees with the findings based on the sampling and extrapolation methodology that was used, the burden of proof of compliance rests with the provider.

(1) The provider must present evidence to show that the sample was invalid. The evidence must include an additional sample of claims, from the same universe, selected on the basis of recognized and generally accepted sampling methods sufficient to ensure a minimum 95% confidence level.

(2) The provider's intent to perform additional audit/review work must be communicated to the agency within the time constraints of the designated appeal. Any such audit must:

(A) be arranged and paid for by the provider;

(B) be conducted by an independent certified public accountant or peer review organization;

(C) demonstrate that a statistically significant higher number of claims and records not reviewed in the agency's sample were in compliance with program regulations; and

(D) be submitted to the agency with all supporting documentation within 120 days of the agency's original final report. Time extensions may be granted, for an additional

period not to exceed ninety days, upon written request from the provider.



**317:30-5-96. Reimbursement for inpatient services**

(a) **Reimbursement for inpatient hospital services.** Reimbursement for inpatient hospital services is made based on a prospective per diem level of care payment system. The per diem includes all non-physician services furnished either directly or under arrangements. This does not include reimbursement for services in Residential Psychiatric Treatment Facilities.

(1) **Components.** There are three distinct payment components under this system. Total per diem reimbursement under the new reimbursement system will equal the sum of two rate components:

(A) Level of care per diem; plus

(B) Fixed capital per diem.

(2) **Level of care per diem rates.** The level of care per diem rate is payment for operating costs and movable capital costs. Hospitals with actual costs above the statewide median level of care will be limited to reimbursement of the statewide median level of care rate. The median was calculated by level of care using FY 1988 base year operating and moveable capital costs trended forward to the beginning of the third quarter FY 1991. Beginning July 1, 1993, when a hospital's actual costs are less than the statewide median level of care, 25 percent of the difference between the statewide median level of care rate and the hospital's specific level of care cost will be added to the level of care rate.

(A) **Level of care.** The only level of care is psychiatric care (Level 6). The range of primary diagnosis codes is 290 through 316.

(B) **Adjustments.** Level of care per diem rates will be reviewed periodically and adjusted as necessary through a public process.

(3) **Fixed capital per diem.**

(A) **Fixed capital per diem methodology for freestanding psychiatric hospitals.** Inpatient psychiatric hospitals fixed rate capital cost will be reimbursed using the average fixed capital cost of all Medicaid enrolled freestanding

psychiatric inpatient hospitals from calendar year 1991 cost reports.

(B) **Adjustments.** The statewide fixed capital per diem average of all freestanding psychiatric hospitals will be reviewed periodically and adjusted as necessary through a public process.

**(4) Disproportionate share hospitals (DSH).**

(A) **Eligibility.** A hospital shall be deemed a disproportionate share hospital, as defined by Section 1923 of the federal Social Security Act, if the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state or if the hospital's low-income utilization rate exceeds 25%.

(i) Eligibility for disproportionate share hospital payments will be determined annually by the OHCA before the beginning of each federal fiscal year based on cost and revenue survey data completed by the hospitals. The survey must be received by OHCA each year by April 30. The information used to complete the survey must be extracted from the hospital's financial records and fiscal year cost report ending in the most recently completed calendar year, for entities that meet the Medicare Provider designation (refer to Medicare Program Memorandum No. A-96-7 for requirements). A hospital may not include costs or revenues on the survey which are attributable to services rendered in a separately licensed/certified entity. Hospitals found to be ineligible for disproportionate share status upon audit shall be required to reimburse the Authority for any disproportionate share payment adjustments paid for the period of ineligibility.

(ii) Beyond meeting either of the tests found in (i) of this subparagraph, there are three additional requirements which are:

(I) Any hospital offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries. This requirement does not apply to children's hospitals.

(II) In the case of an urban hospital, a hospital located in an MSA, an "obstetrician" is defined as any board-certified obstetrician with staff privileges who performs non-emergency obstetrical services at the hospital. In the case of a rural hospital, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital.

(III) A hospital must have a Medicaid inpatient utilization rate of at least one percent.

**(B) Payment adjustment.**

(i) Beginning federal fiscal year 1993 and each year thereafter, DSH payment adjustments will be capped by the federal government. Financial participation from the federal government will not be allowed for expenditures exceeding the capped amount. Eligible DSH hospitals will be assigned to one of the three following categories:

(I) public-private acute care teaching hospital which has 150 or more full-time equivalent residents enrolled in approved teaching programs (using the most recently completed annual cost report) and is licensed in the state of Oklahoma. Public-private hospital is a former state operated hospital that has entered into a joint operating agreement with a private hospital system;

(II) other state hospitals; or

(III) private hospitals and all out-of-state hospitals.

(ii) Payment adjustments will be made on a quarterly basis for federal fiscal year 1994 and thereafter using the following formula that determines the hospital's annual allocation:

(I) Step 1. The Medicaid revenue and imputed revenue for charity are totaled for each hospital qualifying for disproportionate share adjustments.

(II) Step 2. A weight is assigned to each qualifying hospital by dividing each hospital's revenue total

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**OAC 317:30-5-96 (p4)**

(Medicaid and charity) by the revenue total of the public-private acute care teaching hospital, which has the assigned weight of 1.0.

(III) Step 3. A weighted value is then determined for each hospital by multiplying the hospital's assigned weight by the hospital's total Medicaid and charity revenue.

(IV) Step 4. The weighted values of all hospitals qualifying for disproportionate share adjustments are totaled.

(V) Step 5. The percentage of the public-private acute care teaching hospital's weighted value is determined in relation to the weighted values of all qualifying disproportionate share hospitals.

(VI) Step 6. The weighted values of all state hospitals (except public-private acute care teaching hospital) are totaled.

(VII) Step 7. The weighted values of all private and out-of-state hospitals qualifying for disproportionate share adjustments are totaled.

(VIII) Step 8. The percentage of the total weighted values of the hospitals included in Step 6 (State hospitals except public-private acute care teaching hospital) is calculated in relation to the total weighted values (sum of Step 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(IX) Step 9. The percentage of weighted values of the hospitals included in Step 7 (private hospitals and all out-of-state hospitals) is calculated in relation to the total weighted values (sum of Steps 6 and 7) of all remaining hospitals qualifying for disproportionate share adjustment.

(X) Step 10. The weighted percentages for the three hospital groups are next applied to the capped disproportionate share amount allowed by HCFA for the federal fiscal year. The amount of disproportionate

share to be paid to the public-private acute care teaching hospital is determined by multiplying the state disproportionate share allotment by the weighted percentage of the public-private acute care teaching hospital. Beginning FFY 96, the weighted percentage amount to be paid will not exceed 82.82%. Payment of disproportionate share funds to public/private hospitals will be made to the public entity that is organizationally responsible for indigent care. The weighted percentage amount is then subtracted from the state disproportionate share allotment. Once the public-private acute care teaching hospital's share of the state disproportionate share allotment has been subtracted, the state hospitals' weighted percentage is applied to the remainder. Beginning FFY 96, the State hospital's weighted percentage (from VIII of this subunit) will not be less than 75.3%. The balance of the disproportionate share allotment is distributed to private hospitals and all out-of-state hospitals. Distribution of funds within each group will be made according to the relationship of each hospital's weighted value to the total weighted value of the group.

(iii) Payment adjustments to individual hospitals will be limited to 100 percent of the hospital's costs of providing services (inpatient and outpatient) to Medicaid recipients and the uninsured, net of payments received from Medicaid (other than DSH) and uninsured patients.

**(5) Out-of-state hospitals.**

(A) Out-of-state hospitals, for which the Authority has on file a fiscal year 1989 or more recent cost report, shall be reimbursed as follows:

(i) the level of care per diem rate

(ii) a fixed capital per diem

(iii) a hospital-specific per diem direct medical education rate.

(B) Hospitals, for which the Authority does not have a fiscal year 1989 or more recent cost report on file, will also receive the level of care per diem rates; however, capital

and direct medical education rate components will not be reimbursed on a hospital-specific basis. Instead, these hospitals shall receive the statewide median capital per diem amount. The statewide median direct medical education per diem rate will be paid to qualifying hospitals.

**(b) Reimbursement for residential psychiatric treatment facilities.** Effective July 1, 1998, reimbursement for residential psychiatric treatment facilities is at a state-wide per diem system according to the facility category. There are two distinct payment components under this system. Total per diem reimbursement will equal a statewide median per diem operating and movable capital amount plus a statewide median per diem fixed capital amount.

**(1) In-State facilities.** The rates were calculated using peer grouped residential treatment facility 1989 or 1990 audited cost reports. Costs were inflated to a common point in time prior to calculation of the median cost per day.

**(A) Hospital Based and Freestanding.**

**(i) Accreditation.** Hospital-Based and Freestanding facilities must be fully accredited by JCAHO, AOA, or CARF as a psychiatric facility or program and be licensed as a residential child care facility.

**(ii) Reimbursement (Private).** The reimbursement rate is an all-inclusive per diem. The facility must furnish, either directly or under arrangements, all non-physician services, including prescribed drugs.

**(iii) Reimbursement (State Owned and Operated).** Facilities owned and operated by the State of Oklahoma will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (HCFA 2552) filed with the OHCA.

**(B) Community Based.**

**(i) Accreditation.** Community based facilities must be fully accredited by JCAHO, AOA, or CARF as a psychiatric facility or program and licensed as a child placing agency.

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(ii) **Reimbursement.** Payment shall be for routine per diem services, exclusive of ancillary and physician services. Ancillary and physician services are reimbursed separately on a fee for service basis.

**(2) Out-of-state facilities.**

(A) **Accreditation.** Out-of-state facilities must be fully accredited by JCAHO, AOA, or CARF as a psychiatric facility or program and be appropriately state licensed.

(B) **Reimbursement.** Facilities shall be reimbursed in the same manner as in-state residential psychiatric treatment centers. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the recipient, OHCA may negotiate an all-inclusive per diem rate.



### **317:30-5-134. Nurse Aide Training Reimbursement**

(a) Nurse Aide training programs and competency evaluation programs occur in two settings, a nursing facility setting and private training courses. Private training includes, but is not limited to, certified training offered at vocational technical institutions. This rule outlines payment for training in either setting.

(b) In the case of nurse aides trained and tested in a Medicaid contracted nursing facility training program, payment is made by the Oklahoma Health Care Authority in the daily per diem rate paid the nursing facility. In the case a nursing facility provides training and competency evaluation in a program that is not properly certified under federal law, the Oklahoma Health Care Authority may offset the nursing facility's payment for monies paid to the facility for these programs. Such action shall occur after notification to the facility of the period of non-certification and the amount of the payment by the Oklahoma Health Care Authority.

(c) In the case of nurse aide training provided in private training courses, reimbursement is made to nurse aides who have paid a reasonable fee for training in a certified training program at the time training was received. The federal regulations prescribe applicable rules regarding certification of the program and certification occurs as a result of certification by the State Survey Agency. For nurse aides to receive reimbursement for private training courses, all of the following requirements must be met:

(1) the training and competency evaluation program must be certified at the time the training occurred;

(2) the nurse aide has paid for training;

(3) a reasonable fee was paid for training (however, reimbursement will not exceed the maximum amount set by the Oklahoma Health Care Authority);

(4) the Oklahoma Health Care Authority is billed by the nurse aide receiving the training within 12 months of the completion of the training;

(5) the nurse aide has passed her or his competency evaluation; and

(6) the nurse aide is employed at a Medicaid contracted nursing facility as a nurse aide during all or part of the year after completion of the training and competency evaluation.

(d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide based upon the following pro-rata formula:

(1) For every month employed in a nursing facility, OHCA will pay 1/12 of the sum of eligible expenses incurred by the nurse aide. The term Aevery month@ is defined as a period of 16 days or more within one month.

(2) The maximum amount paid by the Oklahoma Health Care Authority may be set by the Rates and Standards Committee. The rate paid by the nurse aide, up to the maximum set by the Oklahoma Health Care Authority, will be paid in the event a nurse aide was employed all 12 months after completion of the training program.

(e) The claimant must submit a completed Nurse Aide Training Reimbursement Program Form and FIN-12 claim voucher. Documentation of eligible expenses must also be provided. Eligible expenses include course training fees, textbooks and exam fees.

(f) No nurse aide trained in a nursing facility program that has an offer of employment or is employed by the nursing facility in any capacity at the inception of the training program may be charged for the costs associated with the nurse aide training or competency evaluation program.

317:30-5-907. Eligible providers

Diagnostic testing entities must be Medicare certified as Mobile X-ray or Independent Diagnostic Testing Facilities (IDTF). Providers must have a current contract on file with the Oklahoma Health Care Authority.



317:30-5-907.1. Coverage by category

(a) **Adults.** Payment is made for the technical component on outpatient diagnostic procedures in accordance with the guidelines set forth in OAC 317:30-5-24.

(b) **Children.** Coverage is the same as adults.



**MEDICAL PROVIDERS-FEE FOR SERVICE  
DIAGNOSTIC TESTING ENTITIES**

**OAC 317:30-5-907.2**

**317:30-5-907.2. Individuals eligible for Part B of Medicare**

Payment is made utilizing the Medicaid allowable for comparable services.



317:30-5-907.3. Reimbursement

Reimbursement will be based on the current allowed charge for radiological procedures.



**317:35-6-64.1. Transitional Medical Assistance (TMA)**

**(a) Conditions for TMA.**

(1) **Transitional Medical Assistance.** Health benefits are continued when the benefit group loses eligibility due to new or increased earnings of the parent(s)/caretaker relative or the receipt of child or spousal support. The health benefit coverage is of the same amount, duration, and scope as if the benefit group continued receiving health benefits. Eligibility for TMA begins with the effective date of case closure or the effective date of closure had the income been reported timely. An individual is included for TMA only if that individual was eligible for Medicaid and included in the benefit group at the time of the closure. To be eligible for TMA the benefit group must meet all of the requirements listed in (A) - (C) of this paragraph.

(A) At least one member of the benefit group was included in at least three of the six months immediately preceding the month of ineligibility.

(B) The health benefit cannot have been received fraudulently in any of the six months immediately preceding the month of ineligibility.

(C) The benefit group must have included a dependent child who met the age and relationship requirements for Medicaid and whose needs were included in the benefit group at the time of closure, unless the only eligible child is a Supplemental Security Income (SSI) recipient.

(2) **Closure due to child support or spousal support.** Health benefits are continued if the case closure is due to the receipt of new or increased child support or payments for spousal support in the form of alimony. The needs of the parent(s) or caretaker relative must be included in the benefit group at the time of closure. The health benefits are continued for four months.

(3) **Closure due to new or increased earnings of parent(s) or**

**caretaker relative.** Health benefits are continued if the closure is due to the new or increased earnings of the parent(s) or caretaker relative. The needs of the parent(s) or caretaker relative must be included in the benefit group at the time of closure. The parent(s) or caretaker relative is required to cooperate with Child Support Enforcement Division during the period of time the family is receiving TMA.

(4) **Eligibility period.** Health benefits may be continued for a period up to 12 months if the reason for closure is new or increased earnings of the parent(s) or caretaker relative. This period is divided into two six-month periods with eligibility requirements and procedures for each period.

(A) **Initial six-month period.**

(i) The benefit group is eligible for an initial six-month period of TMA without regard to income or resources if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same; and

(III) the benefit group remains in the state.

(ii) An individual benefit group family member remains eligible for the initial six-month period of TMA unless the individual:

(I) moves out of the state,

(II) dies,

(III) becomes an inmate of a public institution,

(IV) leaves the household,

(V) does not cooperate, without good cause, with the Child Support Enforcement Division or third party liability requirements.

**(B) Additional Six-month period.**

(i) Health benefits are continued for the additional six-month period if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same;

(III) the benefit group remains in the state;

(IV) the benefit group was eligible for and received TMA for each month of the initial six-month period;

(V) the benefit group has complied with reporting requirements in subsection (g) of this Section;

(VI) the benefit group has average monthly earned income (less child care costs that are necessary for the employment of the parent or caretaker relative) that does not exceed the 185% of the Federal Poverty Level (see OKDHS Appendix C-1, Schedule I.A); and

(VII) the parent(s) or caretaker relative had earnings in each month of the required three-month reporting period described in (g)(2) of this Section, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause.

(ii) An individual benefit group family member remains eligible for the additional six-month period unless the individual meets any of the items listed in (4)(A)(ii) of this paragraph.

**(b) Income and resource eligibility.**

(1) The unearned income and resources of the benefit group are disregarded in determining eligibility for TMA. There is no earned income test for the initial six-month period.

(2) Health benefits are continued for the additional six-month

period if the benefit group's countable earnings less child care costs that are necessary for the employment of the parent(s) or caretaker relative are below 185% of the Federal Poverty Level (see OKDHS Appendix C-1, Schedule I.A) and the benefit group meets the requirements listed in (a)(4)(B).

(A) The earnings of all benefit group members are used in determining the earned income test. The only exception is that earnings of full time students included in the benefit group are disregarded.

(B) Income is determined by averaging the benefit group's gross monthly earnings (except full time student earnings) for the required three-month reporting period.

(C) A deduction from the benefit group's earned income is allowed for the cost of approved child care ■ 1 necessary for the employment of the parent(S) or caretaker relative. The child care deduction is averaged for the same three-month reporting period. There is no maximum amount for this deduction.

(D) All individuals whose earnings are considered are included in the benefit group. The family size remains the same during both reporting periods.

(c) **Eligible child.** When the regular health benefit is closed and TMA begins, the benefit group must include an eligible child whose needs were included in the health benefit at the time of closure, unless the only eligible child is a SSI recipient. After the TMA begins, the benefit group must continue to include an eligible child. Age is the only requirement an eligible child must meet.

(d) **Additional members.** After the TMA begins, family members who move into the home cannot be added to the TMA coverage. This includes siblings and a natural or adoptive parent(s) or caretaker relative. If the additional member is in need of health benefits, an application for services under the regular Medicaid program is completed. If a benefit group member included in TMA leaves the home and then returns, that member may be added back to TMA coverage if all conditions of eligibility are met.

(e) **Third party liability.** The benefit group's eligibility for TMA is not affected by a third party liability. However, the benefit group is responsible for reporting all insurance coverage and any changes in the coverage. The social services specialist must explain the necessity for applying benefits from private insurance to the cost of medical care.

(f) **Notification.**

(1) **Notices.** Notices are sent to the benefit group, both at the onset of and throughout the TMA period. These notices, which are sent at specific times, inform the benefit group of its rights and responsibilities. When a health benefit is closed and the benefit group is eligible for TMA, the computer generated closure notice includes notification of the continuation of health benefits. Another computer generated notice is sent at the same time to advise the benefit group of the reporting requirements and under what circumstances the health benefits may be discontinued. Each notice listed in (A)-(C) of this paragraph includes specific information about what the benefit group must report. The notices serve as the required advance notification in the event benefits are discontinued as a result of the information furnished in response to these notices.

(A) **Notice #1.** Notice #1 is issued in the third month of the initial TMA period. This notice advises the benefit group of the additional six-month period of TMA, the eligibility conditions, reporting requirements, and appeal rights.

(B) **Notice #2.** Notice #2 is issued in the sixth month of the TMA period, but only if the benefit group is eligible for the additional six-month period. This notice advises the benefit group of the eligibility conditions, reporting requirements, and appeal rights.

(C) **Notice #3.** Notice #3 is issued in the ninth month of the TMA period, or the third month of the additional six-month period. This notice advises the benefit group of the eligibility conditions, the reporting requirements, appeal rights, and the expiration of TMA coverage.

(2) **Notices not received.** In some instances the benefit group does not receive all of the notices listed in(1) of this subsection. The notices and report forms are not issued retroactively.

(g) **Reporting.** The benefit group is required to periodically report specific information. The information may be reported by telephone, in an office interview, or by letter.

(1) The benefit group must report:

(A) gross earned income of the entire benefit group for the appropriate three-month period;

(B) child care expenses, for the appropriate three-month period, necessary for the continued employment of the parent(s) or caretaker relative;

(C) changes in members of the benefit group;

(D) residency; and

(E) third party liability.

(2) The reporting requirement time frames are explained in this subparagraph.

(A) The information requested in the third month must be received by the 21st day of the fourth month and is used to determine the benefit group's eligibility for the additional six-month period. While this report is due in the fourth month, negative action cannot be taken during the initial period for failure to report. If the benefit group fails to submit the requested information, benefits are automatically suspended effective the seventh month. If action to reinstate is not taken by deadline of the suspension month, the computer automatically closes the case effective the next month.

(B) The information requested in the sixth month must be furnished by the 21st day of the seventh month. The decision

to continue benefits into the eighth month is determined by the information reported.

(C) The information requested in the ninth month must be furnished by the 21st day of the tenth month. The decision to continue health benefits into the 11th month is determined by the information reported. When the information is not reported timely, the TMA is automatically suspended by the computer for the appropriate effective date. If the benefit group subsequently reports the necessary information, the social services specialist determines eligibility. If all eligibility factors are met during and after the suspension period, the health benefits are reinstated. The effective date of the reinstatement is the same as the effective date of the suspension so the benefit group has continuous medical coverage.

(h) **Termination of TMA.** The TMA coverage is discontinued any time the benefit group fails to meet the eligibility requirements as shown in this Section. If it becomes necessary to discontinue the TMA coverage for the benefit group or any member of the benefit group, the individual(s) must be advised that he or she may be eligible for health benefits under the regular Medicaid program and how to obtain these benefits.

(i) **Receipt of health benefits after TMA ends.** To ensure continued medical coverage a computer generated recertification form is mailed to the benefit group during the third month of TMA for benefits closed due to the receipt of child or spousal support or the 11th month of TMA for benefits closed due to increased earnings. The benefit group must return the form prior to the termination of the TMA benefits. When determined eligible, health benefits continue as health benefits not TMA. If the benefit group fails to return the recertification form, TMA benefits are terminated.

**INSTRUCTIONS TO STAFF:**

1. See OAC 317:35-10-26(b)(4)(B)(iv).