

Volume 25
Number 4
November 1, 2007
Pages 99 - 182

The Oklahoma Register

Oklahoma
Secretary of State
Office of Administrative Rules



Brad Henry, Governor
M. Susan Savage,
Secretary of State
Peggy Coe, Managing Editor

THE OKLAHOMA REGISTER is an official publication of the State of Oklahoma. It is published semi-monthly on the first working day of the month and on the first working day following the 14th day of the month under the authority of 75 O.S., Sections 250 et seq. and OAC 655:10-15-1. The rules of the State of Oklahoma are codified and published in the *Oklahoma Administrative Code*.

The *Oklahoma Register* and the documents accepted for publication are **AVAILABLE FOR PUBLIC INSPECTION** at the Office of Administrative Rules pursuant to the Oklahoma Open Records Act. Copies of the *Register* are also available for public inspection at many County Clerks' offices in Oklahoma, the Jan Eric Cartwright Memorial Law Library in the State Capitol, and the following depository libraries:

Ada - East Central University, Linscheid Library

Alva - Northwestern Oklahoma State University,
J.W. Martin Library

Bartlesville - Bartlesville Public Library

Clinton - Clinton Public Library

Durant - Southeastern Oklahoma State University, H.G.
Bennett Memorial Library

Edmond - University of Central Oklahoma, Chambers Library

Enid - Public Library of Enid and Garfield County

Goodwell - Oklahoma Panhandle State University

Lawton - Lawton Public Library

McAlester - McAlester Public Library

Norman - University of Oklahoma, Bizzell Memorial
Library

Oklahoma City - Metropolitan Library System

Oklahoma City - Oklahoma Department of Libraries

Stillwater - Oklahoma State University, Edmon Low
Library

Tahlequah - Northeastern State University, John
Vaughan Library

Tulsa - Tulsa City-County Library System

Tulsa - University of Tulsa, McFarlin Library

Weatherford - Southwestern Oklahoma State
University, Al Harris Library

CITE MATERIAL PUBLISHED IN THE OKLAHOMA REGISTER by the volume and the beginning page number of the document in the *Register*. For example: 25 Ok Reg 256.

SUBSCRIPTION RATES for the *Register* are \$500.00 per year for the printed issues and \$300.00 per year for the CD-ROM issues, payable in advance. When available, individual printed issues may be purchased for \$20.00 plus the cost of postage, payable in advance. Make checks payable to "Secretary of State." Send subscription requests, change of address notices, and undelivered copies to: Secretary of State, Office of Administrative Rules, P.O. Box 53390, Oklahoma City, OK 73152-3390.

INFORMATION ABOUT THIS PUBLICATION may be obtained by contacting the Oklahoma Secretary of State, Office of Administrative Rules, 2401 North Lincoln Boulevard, Will Rogers Building, Room 220, P.O. Box 53390, Oklahoma City, OK 73152-3390, or by calling (405) 521-4911 or faxing (405) 522-3555. Office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday.

This publication is issued and printed by the Secretary of State as authorized by 75 O.S., Section 255. 70 copies have been prepared and distributed at a cost of \$495.60. Copies have been deposited with the Oklahoma Department of Libraries, Publications Clearinghouse.

ISSN 0030-1728

Table of Contents

Agency/Action/Subject Index	iii
Rules Affected Index	iv
Agency Index (Title numbers assigned)	vi
Notices of Rulemaking Intent	
Conservation Commission, Oklahoma (Title 155)	99
Environmental Quality, Department of (Title 252)	99
Submissions for Review	
Agriculture, Food, and Forestry, Oklahoma Department of (Title 35)	101
Gubernatorial Approvals	
Agriculture, Food, and Forestry, Oklahoma Department of (Title 35)	103
Emergency Adoptions	
Health, Oklahoma State Department of (Title 310)	105
Health Care Authority, Oklahoma (Title 317)	112, 114, 118, 119, 121, 123, 124, 126, 128, 130, 168, 169, 171
Insurance Department (Title 365)	172
Executive Orders (Title 1)	181

Agency/Action/Subject Index

**AGRICULTURE, Food, and Forestry, Oklahoma
Department of (Title 35)**

Submissions for Review

~~Plant Industry~~ Consumer Protection (Chapter 30) 101

Gubernatorial Approvals

~~Plant Industry~~ Consumer Protection (Chapter 30) 103

CONSERVATION Commission, Oklahoma (Title 155)

Notices of Rulemaking Intent

Clean Water State Revolving Fund Program
(Chapter 25) 99

ENVIRONMENTAL Quality, Department of (Title 252)

Notices of Rulemaking Intent

Radiation Management (Chapter 410) 99

GOVERNOR

Executive Orders

Ordering flags at half-staff to honor Staff Sergeant Kevin R.
Brown (07-40) 181

HEALTH, Oklahoma State Department of (Title 310)

Emergency Adoptions

Newborn Screening Program (Chapter 550) 105

HEALTH Care Authority, Oklahoma (Title 317)

Emergency Adoptions

Medical Providers-Fee for Service (Chapter 30) 112,
114, 118, 119, 121, 123, 124, 126

Medical Assistance for Adults and Children-Eligibility
(Chapter 35) 128, 130, 168

Oklahoma Employer and Employee Partnership for Insurance
Coverage (Chapter 45) 169, 171

INSURANCE Department (Title 365)

Emergency Adoptions

Licensure of Producers, Adjusters, Bail Bondsmen,
Companies, Prepaid Funeral Benefits, and Viatical and Life
Settlements Providers and Brokers (Chapter 25) 172

Rules Affected Index

[(E) = Emergency action]

Rule	Register Page	Rule	Register Page
35:17-11-1.	[NEW] (E) 69	317:30-5-421.	[AMENDED] (E) 125
35:17-11-2.	[RESERVED] (E) 69	317:30-5-422.	[AMENDED] (E) 125
35:17-11-3.	[NEW] (E) 69	317:30-5-423.	[AMENDED] (E) 126
35:17, App. A.	[NEW] (E) 71	317:30-5-424.	[AMENDED] (E) 126
87:10-27-2.	[AMENDED] (E) 79	317:30-5-568.	[AMENDED] (E) 118
87:10-27-14.	[NEW] (E) 79	317:30-5-698.	[AMENDED] (E) 127
150:110-1-1.	[AMENDED] (E) 57	317:35-5-8.	[AMENDED] (E) 129
150:110-1-2.	[AMENDED] (E) 57	317:35-5-41.	[AMENDED] (E) 130
155:25-1-1.	[NEW] (E) 7	317:35-5-41.1.	[NEW] (E) 142
155:25-1-2.	[NEW] (E) 8	317:35-5-41.2.	[NEW] (E) 144
210:10-13-2.	[AMENDED] (E) 80	317:35-5-41.3.	[NEW] (E) 145
210:10-17-1.	[AMENDED] (E) 8	317:35-5-41.4.	[NEW] (E) 146
210:15-13-5.	[NEW] (E) 10	317:35-5-41.5.	[NEW] (E) 146
210:15-13-6.	[NEW] (E) 10	317:35-5-41.6.	[NEW] (E) 146
210:15-31-2.	[AMENDED] (E) 82	317:35-5-41.7.	[NEW] (E) 150
210:20-26-3.	[AMENDED] (E) 82	317:35-5-41.8.	[NEW] (E) 151
210:20-27-1.	[AMENDED] (E) 83	317:35-5-41.9.	[NEW] (E) 153
210:25-3-4.	[AMENDED] (E) 84	317:35-5-41.10.	[NEW] (E) 154
210:35-3-186.	[AMENDED] (E) 85	317:35-5-41.11.	[NEW] (E) 154
210:35-5-31.	[NEW] (E) 11	317:35-5-45.	[AMENDED] (E) 154
210:40-9-1.	[NEW] (E) 12	317:35-5-46.	[AMENDED] (E) 155
210:40-9-2.	[NEW] (E) 12	317:35-5-47.	[AMENDED] (E) 155
210:40-9-3.	[NEW] (E) 12	317:35-5-49.	[AMENDED] (E) 155
210:40-89-1.	[NEW] (E) 87	317:35-7-48.	[AMENDED] (E) 129
210:40-89-2.	[NEW] (E) 87	317:35-9-15.	[AMENDED] (E) 155
210:40-91-1.	[NEW] (E) 88	317:35-9-48.1.	[NEW] (E) 169
210:40-91-2.	[NEW] (E) 88	317:35-9-65.	[AMENDED] (E) 157
210:40-91-3.	[NEW] (E) 88	317:35-9-68.	[AMENDED] (E) 158
210:40-91-4.	[NEW] (E) 88	317:35-17-9.	[AMENDED] (E) 161
310:550-1-1.	[AMENDED] (E) 105	317:35-17-11.	[AMENDED] (E) 161
310:550-1-2.	[AMENDED] (E) 105	317:35-19-4.	[AMENDED] (E) 163
310:550-3-1.	[AMENDED] (E) 107	317:35-19-19.	[AMENDED] (E) 165
310:550-5-1.	[AMENDED] (E) 107	317:35-19-21.	[AMENDED] (E) 166
310:550-7-1.	[AMENDED] (E) 108	317:45-9-1.	[AMENDED] (E) 170
310:550-13-1.	[AMENDED] (E) 108	317:45-11-20.	[AMENDED] (E) 170
310:550-17-1.	[AMENDED] (E) 109	317:45-11-21.1.	[NEW] (E) 172
310:550-19-1.	[AMENDED] (E) 109	318:10-1-1.	[AMENDED] (E) 58
310:550-21-1.	[AMENDED] (E) 109	318:10-1-3.1.	[NEW] (E) 58
310:550, App. B.	[REVOKED] (E) 110	340:2-5-112.	[AMENDED] (E) 13
310:550, App. B.	[NEW] (E) 110	340:2-5-119.	[AMENDED] (E) 14
310:550, App. C.	[REVOKED] (E) 111	340:10-2-1.	[AMENDED] (E) 14
310:550, App. C.	[NEW] (E) 111	340:10-2-5.	[AMENDED] (E) 16
317:30-3-59.	[AMENDED] (E) 112	340:10-2-6.	[AMENDED] (E) 16
317:30-5-2.	[AMENDED] (E) 114	340:10-2-7.	[AMENDED] (E) 17
317:30-5-9.	[AMENDED] (E) 121	340:10-2-8.	[AMENDED] (E) 19
317:30-5-18.	[AMENDED] (E) 118	340:75-7-15.	[AMENDED] (E) 21
317:30-5-20.	[AMENDED] (E) 122	340:110-1-9.4.	[AMENDED] (E) 23
317:30-5-70.2.	[AMENDED] (E) 119	340:110-3-5.	[AMENDED] (E) 25
317:30-5-72.1.	[AMENDED] (E) 120	340:110-3-5.1.	[AMENDED] (E) 26
317:30-5-111.	[AMENDED] (E) 113	340:110-3-27.	[AMENDED] (E) 26
317:30-5-290.	[REVOKED] (E) 113	340:110-3-39.	[AMENDED] (E) 28
317:30-5-290.	[AMENDED] (E) 123	340:110-3-40.	[AMENDED] (E) 29
317:30-5-290.1.	[NEW] (E) 124	340:110-3-49.3.	[AMENDED] (E) 29
317:30-5-291.	[AMENDED] (E) 124	340:110-3-81.	[AMENDED] (E) 31
317:30-5-291.1.	[NEW] (E) 124	340:110-3-82.	[AMENDED] (E) 31
317:30-5-291.2.	[NEW] (E) 124	340:110-3-84.	[AMENDED] (E) 32
317:30-5-295.	[NEW] (E) 124	340:110-3-85.	[AMENDED] (E) 32
317:30-5-296.	[NEW] (E) 124	340:110-3-86.	[AMENDED] (E) 35
317:30-5-297.	[NEW] (E) 124	340:110-3-87.	[AMENDED] (E) 37
317:30-5-298.	[NEW] (E) 124	340:110-3-88.	[AMENDED] (E) 37
317:30-5-420.	[AMENDED] (E) 125	340:110-3-89.1.	[AMENDED] (E) 38

340:110-3-90. [AMENDED] (E)	38	365:25-27-7. [NEW] (E)	61
340:110-3-91. [AMENDED] (E)	39	365:25-27-8. [NEW] (E)	63
340:110-3-91.1. [NEW] (E)	39	365:25-27-9. [NEW] (E)	63
340:110-3-92. [AMENDED] (E)	40	530:10, App. A. [REVOKED] (E)	90
340:110-3-93. [AMENDED] (E)	40	530:10, App. A. [NEW] (E)	90
340:110-3-94. [AMENDED] (E)	41	590:10-7-13. [AMENDED] (E)	46
340:110-3-97. [AMENDED] (E)	41	590:10-19-2. [AMENDED] (E)	47
340:110-3-97.1. [AMENDED] (E)	42	590:10-19-3. [AMENDED] (E)	47
340:110-3-223. [AMENDED] (E)	43	600:15-1-2. [AMENDED] (E)	91
340:110-3-224. [AMENDED] (E)	44	600:15-1-4. [AMENDED] (E)	91
340:110-3-237. [AMENDED] (E)	45	710:95-5-3. [AMENDED] (E)	92
365:25-3-1. [AMENDED] (E)	173	710:95-5-11. [AMENDED] (E)	93
365:25-3-1.1. [NEW] (E)	176	710:95-5-13. [REVOKED] (E)	93
365:25-3-1.2. [NEW] (E)	176	710:95-5-14. [REVOKED] (E)	93
365:25-3-1.3. [NEW] (E)	176	710:95-5-15. [REVOKED] (E)	94
365:25-3-14. [AMENDED] (E)	176	710:95-5-16. [REVOKED] (E)	94
365:25-27-1. [NEW] (E)	59	710:95-5-17. [REVOKED] (E)	95
365:25-27-2. [NEW] (E)	59	710:95-5-18. [REVOKED] (E)	95
365:25-27-3. [NEW] (E)	59	710:95-5-19. [NEW] (E)	95
365:25-27-4. [NEW] (E)	59	710:95-5-20. [REVOKED] (E)	95
365:25-27-5. [NEW] (E)	59	710:95-5-21. [REVOKED] (E)	96
365:25-27-6. [NEW] (E)	60	710:95-5-22. [REVOKED] (E)	96

Agency/Title Index

[Assigned as of 11-1-07]

Agency	Title	Agency	Title
Oklahoma ACCOUNTANCY Board	10	State ELECTION Board	230
State ACCREDITING Agency	15	Oklahoma FUNERAL Board (<i>Formerly:</i> Oklahoma State Board of EMBALMERS and Funeral Directors)	235
AD Valorem Task Force (<i>abolished 7-1-93</i>)	20	Oklahoma Department of EMERGENCY Management (<i>Formerly:</i> Department of CIVIL Emergency Management) - <i>See</i> Title 145	
Oklahoma AERONAUTICS Commission	25	Oklahoma EMPLOYMENT Security Commission	240
Board of Regents for the Oklahoma AGRICULTURAL and Mechanical Colleges	30	Oklahoma ENERGY Resources Board	243
Oklahoma Department of AGRICULTURE , Food, and Forestry	35	State Board of Licensure for Professional ENGINEERS and Land Surveyors (<i>Formerly:</i> State Board of Registration for Professional ENGINEERS and Land Surveyors)	245
Oklahoma Board of Licensed ALCOHOL and Drug Counselors	38	Board of Trustees for the ENID Higher Education Program	250
Board of Tests for ALCOHOL and Drug Influence	40	Department of ENVIRONMENTAL Quality	252
ALCOHOLIC Beverage Laws Enforcement Commission	45	State Board of EQUALIZATION	255
ANATOMICAL Board of the State of Oklahoma	50	ETHICS Commission (<i>Title revoked</i>)	257
Board of Governors of the Licensed ARCHITECTS , Landscape Architects and Interior Designers of Oklahoma	55	ETHICS Commission	258
ARCHIVES and Records Commission	60	Office of State FINANCE	260
Board of Trustees for the ARDMORE Higher Education Program	65	State FIRE Marshal Commission	265
Oklahoma ARTS Council	70	Oklahoma Council on FIREFIGHTER Training	268
ATTORNEY General	75	Oklahoma FIREFIGHTERS Pension and Retirement System	270
State AUDITOR and Inspector	80	[RESERVED]	275
State BANKING Department	85	State Board of Registration for FORESTERS	280
Oklahoma State Employees BENEFITS Council	87	FOSTER Care Review Advisory Board	285
Council of BOND Oversight	90	Oklahoma FUNERAL Board (<i>Formerly:</i> Oklahoma State Board of Embalmers and Funeral Directors) - <i>See</i> Title 235	
Oklahoma Professional BOXING Commission	92	Oklahoma FUTURES	290
State BURIAL Board (<i>abolished 7-1-92</i>)	95	GOVERNOR	295
[RESERVED]	100	GRAND River Dam Authority	300
Oklahoma CAPITAL Investment Board	105	Group Self-Insurance Association GUARANTY Fund Board	302
Oklahoma CAPITOL Improvement Authority	110	Individual Self-Insured GUARANTY Fund Board	303
State CAPITOL Preservation Commission	115	STATE Use Committee (<i>Formerly:</i> Committee on Purchases of Products and Services of the Severely HANDICAPPED)	304
CAPITOL-MEDICAL Center Improvement and Zoning Commission	120	Office of HANDICAPPED Concerns	305
Oklahoma Department of CAREER and Technology Education (<i>Formerly:</i> Oklahoma Department of VOCATIONAL and Technical Education) - <i>See</i> Title 780		Oklahoma State Department of HEALTH	310
Board of Regents of CARL Albert State College	125	Oklahoma Basic HEALTH Benefits Board (<i>abolished 11-1-97</i>)	315
Department of CENTRAL Services (<i>Formerly:</i> Office of PUBLIC Affairs) - <i>See</i> Title 580		Oklahoma HEALTH Care Authority	317
CEREBRAL Palsy Commission	130	HIGHWAY Construction Materials Technician Certification Board	318
Commission on CHILDREN and Youth	135	Oklahoma HISTORICAL Society	320
Board of CHIROPRACTIC Examiners	140	Oklahoma HORSE Racing Commission	325
Oklahoma Department of EMERGENCY Management (<i>Formerly:</i> Department of CIVIL Emergency Management)	145	Oklahoma HOUSING Finance Agency	330
Oklahoma Department of COMMERCE	150	Oklahoma HUMAN Rights Commission	335
COMMUNITY Hospitals Authority	152	Department of HUMAN Services	340
COMPSOURCE Oklahoma (<i>Formerly:</i> State INSURANCE Fund) - <i>See</i> Title 370		Committee for INCENTIVE Awards for State Employees	345
Oklahoma CONSERVATION Commission	155	Oklahoma INDIAN Affairs Commission	350
CONSTRUCTION Industries Board	158	Oklahoma INDIGENT Defense System	352
Department of CONSUMER Credit	160	Oklahoma INDUSTRIAL Finance Authority	355
CORPORATION Commission	165	INJURY Review Board	357
Department of CORRECTIONS	170	Oklahoma State and Education Employees Group INSURANCE Board	360
State Board of COSMETOLOGY	175	INSURANCE Department	365
Oklahoma State CREDIT Union Board	180	COMPSOURCE Oklahoma (<i>Formerly:</i> State INSURANCE Fund)	370
CRIME Victims Compensation Board	185	Oklahoma State Bureau of INVESTIGATION	375
Joint CRIMINAL Justice System Task Force Committee	190	Council on JUDICIAL Complaints	376
Board of DENTISTRY	195	Office of JUVENILE Affairs	377
Oklahoma DEVELOPMENT Finance Authority	200	Department of LABOR	380
Board of Regents of EASTERN Oklahoma State College	205	Department of the Commissioners of the LAND Office	385
State Department of EDUCATION	210		
EDUCATION Oversight Board	215		
Oklahoma EDUCATIONAL Television Authority	220		
[RESERVED]	225		

Agency	Title	Agency	Title
Council on LAW Enforcement Education and Training	390	Board of Regents of REDLANDS Community College	607
Oklahoma LAW Enforcement Retirement System	395	State REGENTS for Higher Education	610
Board on LEGISLATIVE Compensation	400	State Department of REHABILITATION Services	612
Oklahoma Department of LIBRARIES	405	Board of Regents of ROGERS State College	615
LIEUTENANT Governor	410	Board of Regents of ROSE State College	620
Oklahoma LINKED Deposit Review Board	415	Oklahoma SAVINGS and Loan Board (<i>abolished 7-1-93</i>)	625
Oklahoma LIQUEFIED Petroleum Gas Board	420	SCENIC Rivers Commission	630
Oklahoma LIQUEFIED Petroleum Gas Research, Marketing and Safety Commission	422	Oklahoma Commission on SCHOOL and County Funds Management	635
LITERACY Initiatives Commission	425	Advisory Task Force on the Sale of SCHOOL Lands (<i>functions concluded 2-92</i>)	640
LONG-RANGE Capital Planning Commission	428	The Oklahoma School of SCIENCE and Mathematics	645
Oklahoma State Board of Examiners for LONG-TERM Care Administrators (<i>Formerly: Oklahoma State Board of Examiners for NURSING Home Administrators</i>) - See Title 490		Oklahoma Center for the Advancement of SCIENCE and Technology	650
LOTTERY Commission, Oklahoma	429	SECRETARY of State	655
Board of Trustees for the MCCURTAIN County Higher Education Program	430	Department of SECURITIES	660
Commission on MARGINALLY Producing Oil and Gas Wells	432	Board of Regents of SEMINOLE State College	665
State Board of MEDICAL Licensure and Supervision	435	SHEEP and Wool Commission	670
MEDICAL Technology and Research Authority of Oklahoma	440	State Board of Licensed SOCIAL Workers	675
Board of MEDICOLEGAL Investigations	445	SOUTHERN Growth Policies Board	680
Department of MENTAL Health and Substance Abuse Services	450	Oklahoma SOYBEAN Commission (<i>abolished 7-1-97</i>)	685
MERIT Protection Commission	455	Board of Examiners for SPEECH-LANGUAGE Pathology and Audiology	690
MILITARY Planning Commission, Oklahoma Strategic	457	STATE Employee Charitable Contributions, Oversight Committee for (<i>Formerly: STATE Agency Review Committee</i>)	695
Department of MINES	460	STATE Use Committee (<i>Formerly: Committee on Purchases of Products and Services of the Severely HANDICAPPED</i>) – See Title 304	
Oklahoma MOTOR Vehicle Commission	465	Oklahoma STUDENT Loan Authority	700
Board of Regents of MURRAY State College	470	TASK Force 2000	705
Oklahoma State Bureau of NARCOTICS and Dangerous Drugs Control	475	Oklahoma TAX Commission	710
Board of Regents of NORTHERN Oklahoma College	480	Oklahoma Commission for TEACHER Preparation	712
Oklahoma Board of NURSING	485	TEACHERS' Retirement System	715
Oklahoma State Board of Examiners for LONG-TERM Care Administrators (<i>Formerly: Oklahoma State Board of Examiners for NURSING Home Administrators</i>)	490	State TEXTBOOK Committee	720
Board of Regents of OKLAHOMA City Community College	495	Oklahoma TOURISM and Recreation Department	725
Board of Regents of OKLAHOMA Colleges	500	Department of TRANSPORTATION	730
Board of Examiners in OPTOMETRY	505	Oklahoma TRANSPORTATION Authority (<i>Name changed to Oklahoma TURNPIKE Authority 11-1-05 - See Title 731</i>)	
State Board of OSTEOPATHIC Examiners	510	Oklahoma TURNPIKE Authority (<i>Formerly: Oklahoma TRANSPORTATION Authority AND Oklahoma TURNPIKE Authority - See also Title 745</i>)	731
PARDON and Parole Board	515	State TREASURER	735
Oklahoma PEANUT Commission	520	Board of Regents of TULSA Community College	740
Oklahoma State PENSION Commission	525	Oklahoma TURNPIKE Authority (<i>Name changed to Oklahoma TRANSPORTATION Authority 11-1-99 - no rules enacted in this Title - See Title 731</i>)	745
State Board of Examiners of PERFUSIONISTS	527	Board of Trustees for the UNIVERSITY Center at Tulsa	750
Office of PERSONNEL Management	530	UNIVERSITY Hospitals Authority	752
Oklahoma State Board of PHARMACY	535	UNIVERSITY Hospitals Trust	753
PHYSICIAN Manpower Training Commission	540	Board of Regents of the UNIVERSITY of Oklahoma	755
Board of PODIATRIC Medical Examiners	545	Board of Regents of the UNIVERSITY of Science and Arts of Oklahoma	760
Oklahoma POLICE Pension and Retirement System	550	Oklahoma USED Motor Vehicle and Parts Commission	765
State Department of POLLUTION Control (<i>abolished 1-1-93</i>)	555	Oklahoma Department of VETERANS Affairs	770
POLYGRAPH Examiners Board	560	Board of VETERINARY Medical Examiners	775
Oklahoma Board of PRIVATE Vocational Schools	565	Oklahoma Department of CAREER and Technology Education (<i>Formerly: Oklahoma Department of VOCATIONAL and Technical Education</i>)	780
State Board for PROPERTY and Casualty Rates (<i>abolished 7-1-06; see also Title 365</i>)	570	Oklahoma WATER Resources Board	785
State Board of Examiners of PSYCHOLOGISTS	575	Board of Regents of WESTERN Oklahoma State College	790
Department of CENTRAL Services (<i>Formerly: Office of PUBLIC Affairs</i>)	580	Oklahoma WHEAT Commission	795
PUBLIC Employees Relations Board	585	Department of WILDLIFE Conservation	800
Oklahoma PUBLIC Employees Retirement System	590	WILL Rogers and J.M. Davis Memorials Commission	805
Department of PUBLIC Safety	595		
REAL Estate Appraiser Board	600		
Oklahoma REAL Estate Commission	605		

Notices of Rulemaking Intent

Prior to adoption and gubernatorial/legislative review of a proposed PERMANENT rulemaking action, an agency must publish a Notice of Rulemaking Intent in the *Register*. In addition, an agency may publish a Notice of Rulemaking Intent in the *Register* prior to adoption of a proposed EMERGENCY or PREEMPTIVE rulemaking action.

A Notice of Rulemaking Intent announces a comment period, or a comment period and public hearing, and provides other information about the intended rulemaking action as required by law, including where copies of proposed rules may be obtained.

For additional information on Notices of Rulemaking Intent, see 75 O.S., Section 303.

TITLE 155. OKLAHOMA CONSERVATION COMMISSION CHAPTER 25. CLEAN WATER STATE REVOLVING FUND PROGRAM

[OAR Docket #07-1414]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

155:25-1-1. Purpose [NEW]

155:25-1-2. Receiving and Reviewing Applications [NEW]

SUMMARY:

The proposed new rules would supersede emergency rules to implement 82 O.S. § 1085.65 which requires the OCC to promulgate rules to receive, and review applications for water quality projects submitted to the Clean Water State Revolving Fund Program for implementation of nonpoint source management programs as allowed by the federal Water Quality Act of 1987 for those activities subject to its jurisdiction as specified in the Oklahoma Environmental Quality Act. This rule specifies the process for such receipt and review.

AUTHORITY:

Oklahoma Conservation Commission; 27A O.S. 2001, § 3-2-106 and 82 O.S. Supp. 2006, § 1085.65

COMMENT PERIOD:

Persons may submit oral or written comments to Ben Pollard, Assistant Director, Oklahoma Conservation Commission, 2800 N. Lincoln, Suite 160, Oklahoma City, Oklahoma 73105, (405) 521-2384, FAX (405) 521-6686 or via electronic mail to ben.pollard@conservation.ok.gov, during the period from November 1, 2007, to December 3, 2007. In addition, if a party requests a public hearing as described below, persons may submit oral or written comments during that public hearing.

PUBLIC HEARING:

A public hearing on the proposed rules has not been scheduled, however, pursuant to 75 O.S. Supp. 2006, § 303(B)(9), "persons may demand a hearing" by contacting Ben Pollard, Assistant Director, Oklahoma Conservation Commission, 2800 N. Lincoln, Suite 160, Oklahoma City, Oklahoma 73105, (405)521-2384, FAX(405)521-6686 or via electronic mail at ben.pollard@conservation.ok.gov no later than 4:30 p.m. on December 3, 2007.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, about the increase in the level of direct costs, indirect costs or others costs expected to be incurred by the business entity due to compliance with the proposed rules. Business entities may submit this information in writing from November 1, 2007 to December 3, 2007, to Ben Pollard, Assistant Director, Oklahoma Conservation Commission, 2800 N. Lincoln, Suite 160, Oklahoma City, Oklahoma 73105, (405)521-2384, FAX(405)521-6686 or via electronic mail at ben.pollard@conservation.ok.gov.

COPIES OF PROPOSED RULES:

Copies of the proposed rules may be obtained from the Oklahoma Conservation Commission, 2800 N. Lincoln, Suite 160, Oklahoma City, Oklahoma 73105, (405)521-2384, FAX(405)521-6686.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S. Supp. 2006, § 303(D), a rule impact statement will be prepared and will be available on and after November 19, 2007, at the same location above listed for reviewing and obtaining copies of the proposed rules.

CONTACT PERSON:

Joann Stevenson, Assistant Attorney General, 405-521-3921 or at joann.stevenson@oag.ok.gov.

[OAR Docket #07-1414; filed 10-3-07]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 410. RADIATION MANAGEMENT

[OAR Docket #07-1420]

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Appendix A. Application and Annual Fee Schedule for Radiation Machines [REVOKED]

Appendix A. Application and Annual Fee Schedule for Radiation Machines [NEW]

SUMMARY:

The purpose of the proposed rule is to clarify the appropriate fee category for various machines. The proposed rule changes the description of radiation machines in some fee categories to align the terminology of Appendix A with the rules.

Notices of Rulemaking Intent

Specifically, the term 'particle accelerator' is substituted for 'cyclotron' in Group A, for 'therapeutic accelerator' in Group B-1, and for 'linear accelerator' in Group C-1. The term 'x-ray systems and particle accelerators' is substituted for 'other therapy machines' in Group B-2, and the term 'analytical or industrial x-ray machines' is substituted for 'cabinet x-ray machines' in Group D-2. The current Appendix A does not include a fee category for particle accelerators with beam energies exactly equal to 1 MeV. The proposed rule places these radiation machines in Group B-1. The description of radiation machines included in Group C-1 is further clarified by specifying that the fee category excludes particle accelerators described in Group A. To assist applicants in determining the correct total fee, an example is provided that demonstrates how to calculate fees when registering a combination of two or more machines from different fee groups. No changes to fees will result from this rulemaking.

AUTHORITY:

Environmental Quality Board and Radiation Management Advisory Council powers and duties, 27A O.S. §§2-2-101, 2-2-104, 2-2-201, 2-9-104, and 2-9-105.

COMMENT PERIOD:

Written comments may be delivered or mailed to the contact person from November 1, 2007, through December 5, 2007. Oral comments may be made at the Radiation Management Advisory Council meeting on December 6, 2007, and the Environmental Quality Board meeting on February 29, 2008.

PUBLIC HEARINGS:

Before the Radiation Management Advisory Council at 10:00 a.m. on December 6, 2007, in the Multi-Purpose Room, first floor of the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma 73102.

Before the Environmental Quality Board at 9:30 a.m. on February 29, 2008, in the Multi-Purpose Room, first floor of the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma 73102.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

The DEQ requests that business entities affected by this proposed rule provide the DEQ, within the comment period

and in dollar amounts if possible, the increase or decrease in the level of direct costs such as fees, and the indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule.

COPY OF PROPOSED RULE:

The proposed rule may be obtained from the contact person, reviewed in person at the Department of Environmental Quality, 707 N. Robinson, Oklahoma City, Oklahoma, or reviewed online at the DEQ website at www.deq.state.ok.us/LPDnew/LPProprules.htm.

RULE IMPACT STATEMENT:

The rule impact statement for the proposed rule will be on file at the Department of Environmental Quality and may be requested from the contact person or reviewed online at the DEQ website at www.deq.state.ok.us/LPDnew/LPProprules.htm.

CONTACT PERSON:

Contact Mike Broderick, Environmental Programs Manager, Radiation Management Section, Land Protection Division at mike.broderick@deq.state.ok.us or (405) 702-5100 (phone) or (405) 702-5101 (fax). The DEQ is located at 707 N. Robinson, Oklahoma City, Oklahoma 73102. The mailing address is P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677.

ADDITIONAL INFORMATION:

Persons with disabilities who desire to attend the rulemaking hearing and need an accommodation should notify the contact person three (3) days in advance of the hearing. The TDD relay number is 1-800-522-8506 or 1-800-722-0353, for TDD machine use only.

[OAR Docket #07-1420; filed 10-9-07]

Submissions for Review

Within 10 calendar days after adoption by an agency of a proposed PERMANENT rulemaking action, the agency must submit the proposed rules to the Governor and the Legislature for review. In addition, the agency must publish in the *Register* a "statement" that the rules have been submitted for gubernatorial/legislative review.

For additional information on submissions for gubernatorial/legislative review, see 75 O.S., Section 303.1, 303.2, and 308.

**TITLE 35. OKLAHOMA DEPARTMENT OF
AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. ~~PLANT INDUSTRY~~
CONSUMER PROTECTION**

[OAR Docket #07-1418]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

RULES:

Subchapter 29. Fertilizer

Part 3. Liquid, Dry, and Anhydrous Ammonia

35:30-29-39 [NEW]

SUBMITTED TO GOVERNOR:

September 18, 2007

SUBMITTED TO HOUSE:

September 18, 2007

SUBMITTED TO SENATE:

September 18, 2007

[OAR Docket #07-1418; filed 10-9-07]

Gubernatorial Approvals

Upon notification of approval by the Governor of an agency's proposed PERMANENT rulemaking action, the agency must submit a notice of such gubernatorial approval for publication in the *Register*.

For additional information on gubernatorial approvals, see 75 O.S., Section 303.2.

**TITLE 35. OKLAHOMA DEPARTMENT OF
AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. ~~PLANT INDUSTRY~~
CONSUMER PROTECTION**

[OAR Docket #07-1419]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 29. Fertilizer

Part 3. Liquid, Dry, and Anhydrous Ammonia

35:30-29-39 [NEW]

GUBERNATORIAL APPROVAL:

October 2, 2007

[OAR Docket #07-1419; filed 10-9-07]

Emergency Adoptions

An agency may adopt new rules, or amendments to or revocations of existing rules, on an emergency basis if the agency determines that "an imminent peril exists to the preservation of the public health, safety, or welfare, or that a compelling public interest requires an emergency rule[s] [A]n agency may promulgate, at any time, any such [emergency] rule[s], provided the Governor first approves such rule[s]" [75 O.S., Section 253(A)].

An emergency action is effective immediately upon approval by the Governor or on a later date specified by the agency in the preamble of the emergency rule document. An emergency rule expires on July 15 after the next regular legislative session following promulgation, or on an earlier date specified by the agency, if not already superseded by a permanent rule or terminated through legislative action as described in 75 O.S., Section 253(H)(2).

Emergency rules are not published in the *Oklahoma Administrative Code*; however, a source note entry, which references the *Register* publication of the emergency action, is added to the *Code* upon promulgation of a superseding permanent rule or expiration/termination of the emergency action.

For additional information on the emergency rulemaking process, see 75 O.S., Section 253.

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 550. NEWBORN SCREENING PROGRAM

[OAR Docket #07-1416]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. General Provisions
310:550-1-1 [AMENDED]
310:550-1-2 [AMENDED]
Subchapter 3. Testing of Newborns
310:550-3-1 [AMENDED]
Subchapter 5. Specimen Collection
310:550-5-1 [AMENDED]
Subchapter 7. Hospital Recording
310:550-7-1 [AMENDED]
Subchapter 13. Parent and Health Care Provider Education
310:550-13-1 [AMENDED]
Subchapter 17. Follow-Up for Physicians
310:550-17-1 [AMENDED]
Subchapter 19. Reporting
310:550-19-1 [AMENDED]
Subchapter 21. Information
310:550-21-1 [AMENDED]
Appendix B. Report Form [REVOKED]
Appendix B. Report Form [NEW]
Appendix C. Refusal of the Newborn Screening Blood Test - Religious
Tenets and Practices Refusal [REVOKED]
Appendix C. Refusal Form [NEW]

AUTHORITY:

Oklahoma State Board of Health; 63 O.S. Supp. 2002, Section 1-533 and 63 O.S. 2001, 1-534

DATES:

Public Hearing:

September 13, 2007

Adoption:

September 13, 2007

Approved by Governor:

October 2, 2007

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

The State Board of Health finds an emergency amendment is required to expand the current newborn screening disorder test panel to reflect current practices by screening programs in the United States. Failure to expand the

disorder test panel could result in irreversible health problems or death for affected infants.

ANALYSIS:

This proposal amends the existing rule. This action adds disorders to the mandated newborn screening panel.

CONTACT PERSON:

Pamela King, MPA, RN, Director, Genetics Program, Screening, Special Services and SoonerStart, (405) 271-6617

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

SUBCHAPTER 1. GENERAL PROVISIONS

310:550-1-1. Purpose

Under 63 O.S., Sections 1-533 and 1-534 the following rules and regulations are established concerning the screening of all infants born in Oklahoma for the disorders of phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell diseases, ~~and after June 30, 2004, upon completion of validation studies and establishment of short term follow up services, infants shall be screened for~~ cystic fibrosis, congenital adrenal hyperplasia, ~~and—~~medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD)-, ~~and after October 1, 2007, upon completion of validation studies and establishment of short-term follow-up services, infants shall be screened for~~ biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health.

310:550-1-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Amino Acid Disorders" refers to a group of inherited metabolic conditions in which the body is unable to metabolize or process amino acids properly due to a defective enzyme function. This causes an amino acid or protein build up in the body. If not treated early in life these defects can cause disability, mental retardation or death. Each amino acid disorder

Emergency Adoptions

is associated with a specific enzyme deficiency. Treatment depends on the specific amino acid disorder.

"Biotinidase Deficiency" means an inherited disease caused by the lack of an enzyme that recycles the B vitamin biotin, which if not treated may cause serious complications, including coma and death.

"Certified Laboratory" refers to the Oklahoma State Public Health Laboratory and/or a laboratory approved by the Oklahoma State Department of Health to conduct newborn screening.

"CLIA '88" means the Clinical Laboratory Improvement Amendments of 1988, public law 100-578. This amendment applies to the Federal Law that governs laboratories who examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment, or the assessment of the health of human beings.

"Confirmatory Testing" means definitive laboratory testing needed to confirm a diagnosis.

"Congenital Adrenal Hyperplasia" or "CAH" will refer to the most common form of CAH, 21-hydroxylase deficiency. This genetic disorder is caused by the lack of an enzyme that the adrenal gland uses to process hormones. Serious loss of body salt and water can result in death. In girls the genitalia may appear as a male's, and can result in incorrect sex assignment. Hormone treatment is required for life.

"Congenital Hypothyroidism" means a disease caused by a deficiency of thyroid hormone (thyroxine) production, which if not treated leads to mental and physical retardation.

"Cystic Fibrosis" means a multisystem genetic disorder in which defective chloride transport across membranes causes dehydration of secretions. The result is a production of a thick, viscous mucus that clogs the lungs. This leads to chronic lung infections, fatal lung disease, and also interferes with digestion. Early detection and treatment can prevent malnutrition, and enhance surveillance and treatment of lung infections.

"Days of Age" means the age of a newborn in 24-hour periods so that a newborn is one day of age 24 hours following the hour of birth.

"Department" refers to the Oklahoma State Department of Health.

"Discharge" means release of the newborn from care and custody of a perinatal licensed health facility to the parents or into the community.

"Disorder" means any condition detectable by newborn screening that allows opportunities, not available without screening, for early treatment and management to prevent mental retardation and/or reduce infant morbidity and mortality.

"Fatty Acid Oxidation Disorders" refers to a group of inherited metabolic conditions in which the body is unable to oxidize (breakdown) fatty acids for energy due to a defective enzyme function. If not treated early in life this defect may cause mental retardation or death.

"Form Kit" or "Newborn Screening Form Kit" is a FDA approved (or licensed) filter paper kit bearing a stamped lot number that has been approved by the Commissioner of Health. For an example of a FDA approved kit, see Appendix A, Oklahoma Health Department (OHD) Form Kit #450.

"Galactosemia" means an inherited disease caused by the body's failure to break down galactose due to a defective enzyme function, which if not treated early in life may cause mental retardation or death.

"Hemoglobinopathy" means an inherited hemoglobin disorder.

"Infant" means a child 6 months of age and under.

"Infant's Physician" means the licensed medical or osteopathic physician responsible for the care of the newborn.

"Initial Specimen" means the first blood specimen collected subsequent to birth, pursuant to these procedures.

"Long-term Follow-up" means follow-up services that begin with diagnosis and treatment and continues throughout the lifespan, including parent education, networking, referral, and case coordination.

"Medium-chain acyl coenzyme A dehydrogenase deficiency" or "MCAD" means a genetic disorder of fatty acid metabolism. This disorder can cause metabolic crisis when an infant/child fasts. This crisis can lead to seizures, failure to breathe, cardiac arrest and death. Treatment is effective by preventing fasting.

"Newborn" means an infant 30 days of age and under.

"Newborn Screening" or "newborn screening tests" means screening infants for the disorders of phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell diseases, and after June 30, 2004, upon completion of validation studies and establishment of short term follow up services, screening infants for cystic fibrosis, congenital adrenal hyperplasia, and medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), and after October 1, 2007, upon completion of validation studies and establishment of short-term follow-up services, biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health.

"Newborn Screening Laboratory" means a laboratory operated by the Department or a laboratory certified by the Department to conduct the tests and carry out the follow-up required by these procedures.

"Newborn Screening Program" refers to the Public Health Laboratory and Family Health Services Short-term Follow-up Program at the Oklahoma State Department of Health.

"Newborn Screening Program Coordinator" refers to the coordinator of the Family Health Services Short-term Follow-up Program at the Oklahoma State Department of Health.

"Organic Acid Disorders" refers to a group of inherited metabolic conditions in which the body is unable to metabolize or process organic acids properly. Each organic acid disorder is associated with a specific enzyme deficiency that causes the accumulation of organic acids in blood and urine. The accumulated compounds or their metabolites are toxic, resulting in the clinical features of these disorders including mental retardation and death.

"Pediatric Sub-Specialist" means a physician licensed in Oklahoma, board certified in pediatrics and board certified in a pediatric sub-specialty of pediatric endocrinology, pediatric pulmonology, or pediatric hematology; or a physician licensed in Oklahoma, board certified in pediatrics whose primary area

of practice is pediatric endocrinology, pediatric hematology, pediatric pulmonology, or metabolic specialist.

"Phenylketonuria" or **"PKU"** means an inherited disease caused by the body's failure to convert the amino acid phenylalanine to tyrosine due to defective enzyme function, which if not treated early in life, causes mental retardation.

"Planned Health Care Provider" or "Medical Home" means the health care provider who will be providing health care for the infant after discharge from the hospital.

"Premature Infant" means an infant weighing less than 2500 grams or any live birth before the thirty-seventh week of gestation.

"Repeat Specimen" means an additional newborn screening specimen to be collected after the initial specimen.

"Satisfactory Specimen" means a specimen collected using a single form kit which is suitable in both blood quantity and quality to perform screening for phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell disease, cystic fibrosis, congenital adrenal hyperplasia, ~~and~~ medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), and after October 1, 2007, upon completion of validation studies and establishment of short-term follow-up services, biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health. All requested demographic information on the form kit must be completed. Federal CLIA '88 regulations require that the form kit's laboratory requisition contain sufficient patient data that must include patient's name, date of birth, sex, date of collection, test(s) to be performed, and complete name and address of person requesting the test.

"Screened" means a specimen that has been collected and tested on an infant less than 6 months of age.

"Screening" means a test to sort out apparently well persons who probably have a disease from those who probably do not. A screening test is not intended to be diagnostic.

"Short-term Follow-up" includes services provided by the Department and the health care provider that begins when the laboratory reports an abnormal or unsatisfactory screen result and ends with a diagnosis of normal, lost (repeat testing not achieved), or affected with appropriate treatment and referral has been initiated.

"Sick Infant" means an infant with any condition or episode marked by pronounced deviation from the normal healthy state; illness.

"Sickle Cell Disease" means an inherited disease caused by abnormal hemoglobin(s) which if not treated early in life may result in severe illness, mental retardation or death (one variation is commonly referred to as sickle cell anemia).

"Specimen" means blood collected on the filter paper Newborn Screening Form Kit.

"Submitter" means a hospital, other facility, or physician submitting a Newborn Screening specimen.

"Transfer" means release of the newborn from care and custody from one licensed health facility to another.

"Unsatisfactory Specimen" means a specimen which is not collected on a form kit and/or is not suitable in blood

quantity and quality to perform screening for phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell disease, cystic fibrosis, congenital adrenal hyperplasia, ~~and~~ medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), and after October 1, 2007, upon completion of validation studies and establishment of short-term follow-up services, biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health and/or Federal CLIA '88 regulations are not followed and the form kit's laboratory requisition does not include patient's name, date of birth, sex, date of collection, test(s) to be performed, and complete name and address of person requesting test.

SUBCHAPTER 3. TESTING OF NEWBORNS

310:550-3-1. Testing of newborns

(a) All newborns in Oklahoma shall be tested by a Certified Newborn Screening Laboratory for phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell diseases, ~~and~~ after June 30, 2004, upon completion of validation studies and establishment of short term follow up services, infants shall be screened for cystic fibrosis, congenital adrenal hyperplasia, ~~and~~ medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD) and after October 1, 2007, upon completion of validation studies and establishment of short-term follow-up services, infants shall be screened for biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health; a parent or guardian may refuse screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices.

(b) A parent or guardian who refuses the newborn screening blood test of their newborn on the grounds that such examination conflicts with their religious tenets and practices shall also indicate in writing this refusal utilizing the Newborn Screening Program Parent Refusal Form as illustrated in Appendix C of this Chapter. This signed refusal form shall be placed in the newborn's medical record with a copy sent to the Newborn Screening Program Coordinator.

SUBCHAPTER 5. SPECIMEN COLLECTION

310:550-5-1. Specimen collection

(a) **Specimen collection for hospital births.** For all live hospital births, the physician, licensed or certified birth attendant shall order the collection of a newborn screening specimen on all newborns prior to transfusion, as early as possible after 24 hours of age or immediately prior to discharge, whichever comes first. Due to the need to identify infants at risk for the disorders quickly, the specimen should be collected as early as possible after 24 hours of age. Specimens shall be collected

Emergency Adoptions

on a single Newborn Screening Form Kit using capillary or venous blood. Cord blood is unacceptable. The hospital is responsible for collecting specimens on all infants.

(1) If the initial specimen for any infant is collected prior to 24 hours of age, the hospital and the physician are responsible for notifying the infant's parents verbally and in writing, utilizing the parent educational form on the Newborn Screening Form Kit, that a repeat specimen is necessary at three to five days of age. The infant's physician is responsible for insuring that the repeat specimen is collected.

(2) The hospital is responsible for submitting a Satisfactory Specimen and for documenting all requested information on the form kit including the parent/guardian's name, address, phone or contact phone number and the planned health care provider who will be providing well care for the infant after discharge or if the infant is to be hospitalized for an extended period of time the name of the infant's physician.

(3) The hospital is responsible for documenting specimen collection and results in the infant's hospital record.

(4) Infants who are transferred from one hospital to another during the newborn period shall have specimen collection documented in the infant's hospital record. It is the responsibility of the physician and the receiving hospital to insure the specimen is collected.

(5) It is the responsibility of the hospital and physician to ~~insure~~ ensure that all infants are screened prior to discharge. If an infant is discharged prior to specimen collection, the Newborn Screening Program Coordinator shall be notified. The physician is responsible for ~~insuring~~ ensuring the specimen is collected as required.

(b) **Screening for premature/sick infants.** For all premature/sick infants, the physician shall order the collection of a newborn screening specimen prior to red blood cell transfusion, at three to seven days of age or immediately prior to discharge, whichever comes first. Due to the need to identify infants at risk for the disorders quickly, the specimen should be collected as early as possible after 24 hours of age. It is recommended that a repeat newborn screening specimen be collected at 14 days of age. Specimens shall be collected on the Newborn Screening Form Kit using capillary or venous blood. The hospital and the physician are responsible for ensuring that specimens are collected on all premature/sick infants.

(1) Premature/sick infants screened prior to 24 hours of age must be re-screened between 7-14 days of age.

(2) Premature/sick infants who could not be screened prior to a red blood cell transfusion should be screened by the 7th day of life, with a repeat specimen collected when plasma and/or red cells will again reflect the infant's own metabolic processes and hemoglobin type (the accepted time period to determine hemoglobin type is 90 to 120 days after transfusion).

(3) The recommended follow-up study for an abnormal thyroid screen in a premature infant is a serum free T4 (measured by direct dialysis or an equivalent method) at 7-14 days of age.

(c) **Specimen collection for out-of-hospital births.**

(1) All infants who are not born in a hospital shall be tested at as early as possible after 24 hours of age. The infant's physician, licensed or certified birth attendant is responsible for submitting a Satisfactory Newborn Screening Specimen. If there is not a physician, licensed or certified birth attendant involved in a non-hospital birth, the person attending the birth and the parents of the infant are responsible for submitting a Satisfactory Newborn Screening Specimen.

(2) If a physician examines a child in the first three months of life who was not born in a hospital, or born out of state, the physician will verify that the child has been screened. If the child has not been screened or if results of screening are not available, the physician should submit a Satisfactory Newborn Screening Specimen.

SUBCHAPTER 7. HOSPITAL RECORDING

310:550-7-1. Hospital recording

(a) The hospital shall implement a procedure to ~~assure~~ ensure that a newborn screening specimen has been collected on every newborn and transported to the Newborn Screening Laboratory within 24 - 48 hours of collection.

(b) The hospital shall immediately notify the infant's physician, parents or guardians, and Newborn Screening Program Coordinator if an infant is discharged without a sample having been collected. This notification shall be documented in the infant's hospital record.

(c) If no test results are received within fifteen (15) days after the date of collection, the hospital shall contact the Newborn Screening Laboratory to verify that a specimen had been received. If no specimen has been received, the hospital shall notify the physician.

(d) Any hospital or any other laboratory which collects, handles or forwards newborn screening samples shall keep a log containing name and date of birth of the infant, name of the attending physician, name of the planned health care provider who will be providing well care for the infant after discharge, medical record number, serial number of the Newborn Screening Form Kit used, date the specimen was drawn, date the specimen was forwarded, date the test results were received and the test results.

(e) Specimens should be transported in the manner designated by the Department.

SUBCHAPTER 13. PARENT AND HEALTH CARE PROVIDER EDUCATION

310:550-13-1. Parent and Health Care Provider education

(a) The infant's physician or designee shall have the responsibility to ~~assure~~ ensure that at least one of each newborn's parent or legal guardian is notified about newborn screening and is provided information about the disorders and instructed

to obtain screen results from the planned health care provider or Newborn Screening Program.

(b) The hospital will be responsible or designate a responsible party to distribute the Newborn Screening Program's written educational materials on newborn screening provided by the Department to at least one of each newborn's parent or legal guardian.

(c) Hospitals shall provide ongoing training programs for their employees involved with newborn screening procedures. These training programs shall include methods of collecting a Satisfactory Newborn Screening Specimen.

(d) The hospital is responsible for ~~assuring~~ensuring that employees who collect, handle or perform newborn screening tests are informed of their responsibilities with respect to screening procedures.

SUBCHAPTER 17. FOLLOW-UP FOR PHYSICIANS

310:550-17-1. Follow-up for physicians

(a) If a physician examines a child in the first three months of life, the physician will verify that the child has been screened, and document results in the infant's medical record. If the child has not been screened or if results of screening are not available, the physician should submit a Satisfactory Newborn Screening Specimen within 48 hours or as soon as possible.

(b) On written notification by the Newborn Screening Program of follow-up requirements for a newborn screen result of abnormal, unsatisfactory and less than 24 hours of age at time of collection; the infant's physician or designee will obtain required repeat screening, confirmatory testing, or diagnostic studies, in the timeframe specified so that therapy, when indicated, can be initiated expeditiously.

(c) The infant's physician may selectively rescreen infants as clinically indicated.

(d) Because patients may relocate without a forwarding address or contact information, where these rules place responsibility upon physicians and hospitals to follow-up or notify parents, then that shall be deemed to require only that a reasonable search be made and that if the parents are not contacted that the Newborn Screening Program Coordinator be notified of the non-follow-up or non-notification after efforts to contact the parents have been exhausted.

(e) For appropriate comprehensive medical care, all confirmed cases of congenital hypothyroidism, galactosemia, phenylketonuria, sickle cell disease, cystic fibrosis, congenital adrenal hyperplasia, medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), and after October 1, 2007, upon completion of validation studies and establishment of short-term follow-up services, biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health, should have a referral to a pediatric sub-specialist, and the parent should be referred for

enrollment in newborn screening long-term follow-up services as designated by the Newborn Screening Program. For referral information, please contact the Newborn Screening Short-term Follow-up Program at (405) 271-6617 or 1-800-766-2223, ext. 6617.

SUBCHAPTER 19. REPORTING

310:550-19-1. Physician Reporting

(a) If confirmatory or follow-up testing is not performed by the Newborn Screening Laboratory or through a contract laboratory designated by the Newborn Screening Program, the infant's physician must report to the Newborn Screening Program Coordinator the results within 7 days after the completion of the medical evaluation, using the Department's Newborn Screening Report Form as illustrated in Appendix B of this Chapter. A copy of the confirmatory test results must accompany the report form.

(b) For all diagnosed cases of phenylketonuria, congenital hypothyroidism, galactosemia, sickle cell diseases, cystic fibrosis, congenital adrenal hyperplasia, ~~and~~ medium-chain acyl coenzyme A dehydrogenase deficiency (MCAD), and after October 1, 2007, upon completion of validation studies and establishment of short-term follow-up services, biotinidase deficiency, amino acid disorders, fatty acid oxidation disorders, and organic acid disorders detectable via the Department's laboratory technology utilized in newborn screening and approved by the Commissioner of Health, the infant's physician shall report treatment date if applicable, and referral information to the Newborn Screening Program Coordinator by completing the Department's Newborn Screening Report Form as illustrated in Appendix B of this Chapter.

(c) These reports shall be confidential and may be utilized only for the purpose of ~~assuring~~ensuring service delivery, program administration, data analysis, and evaluation.

SUBCHAPTER 21. INFORMATION

310:550-21-1. Information

(a) For information regarding laboratory procedures, or results of laboratory tests or to order form kits, contact Public Health Laboratory Service, Oklahoma State Department of Health, P.O. Box 24106, Oklahoma City, Oklahoma 73124-0106, (405) 271-5070, FAX (405) 271-4850.

(b) For general information or information regarding follow-up, contact Newborn Screening Short-term Follow-up Program, Family Health Services, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299, (405) 271-6617, FAX (405) 271-4892, 1-800-766-2223, ext. 6617. General information about the Newborn Screening Program is available on the OSDH Web site at ~~www.health.state.ok.us~~www.health.ok.gov.

APPENDIX B. REPORT FORM [REVOKED]

APPENDIX B. REPORT FORM [NEW]

Newborn Screening Program Report Form

Infant's Name: _____ Infant's Birth Date __ __ / __ __ / __ __

Newborn Screening Program Lab #: _____ Mother's Name: _____

Diagnosis pending, Follow-up Plan:

Final Diagnosis (please attach confirmation lab results)

- Normal
- Trait Condition (specify carrier status) _____
- Classic Galactosemia (GG phenotype/genotype)
- Duarte/Galactosemia Compound Heterozygote (DG phenotype/genotype)
- Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency
- Cystic Fibrosis
- Classic Phenylketonuria (PKU)
- Hyperphenylalaninemia (not clinically significant)
- Hyperphenylalaninemia (clinically significant treatment required)
- Congenital Hypothyroidism
- Medium-chain Acyl Coenzyme A Dehydrogenase Deficiency (MCAD)
- Sickle Cell Disease (specify type) _____
- Hemoglobin disease (specify type) _____
- Biotinidase deficiency
- Fatty Acid Oxidation Disorder (specify) _____
- Organic Acid Disorder (specify) _____
- Amino Acid Disorder (specify) _____
- Other (specify) _____

Treatment Indicated? yes no

Date treatment started __ __ / __ __ / __ __

Referred to pediatric sub-specialist:

- Endocrinologist (specify name): _____
- Hematologist (specify name): _____
- Metabolic Specialist (specify name): _____
- Pulmonologist (specify name): _____

Family referred for (check all that apply):

- Genetic counseling (check provider):
 ___ Sickle Cell Association ___ Geneticist ___ Other
- Enrollment in Newborn Screening Long-term Follow-up Program
- Early Intervention Services

Print Physician's Name _____ Telephone _____

Physician Signature _____ Date __ __ / __ __ / __ __

Mail or Fax this follow-up form with complete diagnostic information and confirmation lab results to:

Oklahoma State Department of Health
Family Health Services
ATT: Newborn Screening Program Coordinator
1000 NE Tenth Street
Oklahoma City, OK 73117-1299
Fax: (405) 271-4892

For questions or referral information, please call the Newborn Screening Program Coordinator at (405) 271-6617 or 1-800-766-2223.

APPENDIX C. REFUSAL OF THE NEWBORN SCREENING BLOOD TEST - RELIGIOUS TENETS AND PRACTICES REFUSAL [REVOKED]

APPENDIX C. REFUSAL FORM [NEW]

Oklahoma State Department of Health
Refusal of the Newborn Screening Blood Test
Religious Tenets and Practices Refusal

Infant's Name: _____ Medical Record Number: _____

Date of Birth: __ __ / __ __ / __ __

Attending Physician or Provider, print name: _____

Place of Birth:
__ Hospital, print name _____

__ Birthing Facility, print name _____

__ Home Birth

I have received and read the parent educational brochure printed by the Oklahoma Department of Health on the Newborn Screening blood test. I understand that these disorders are easily detected by testing a small blood sample from my baby's heel.

I have been informed that all newborns are required by law (under 63 O.S. 2002, Sections 1-533 and 1-534) to have a newborn screening test collected.

I have been informed and I understand that this screening is done to detect these disorders because symptoms sometimes do not appear for several weeks or months, and irreversible damage can occur before symptoms become apparent to a family or a physician.

I have been informed and I understand that, if untreated, these conditions may cause permanent damage to my child, including mental retardation, growth failure, and even death. This permanent health damage can be prevented through early detection and treatment.

I have discussed the newborn screening test with my physician or health care provider and I understand the risks to my child if the screening test is not completed.

I understand that the law allows a parent or guardian to refuse newborn screening based on the grounds that such examination conflicts with a person's religious tenets and practices. I elect to refuse newborn screening on that such testing of my infant conflicts with my religious tenets and practices. My decision was made freely and I accept the legal responsibility for the consequences of this decision.

_____/_____
Print Parent/legal Guardian's Name Signature of Parent/legal Guardian Date

_____/_____
Print Witness Name Signature of Witness Date

Original to infant's record, provide a copy to parent, and forward copy by fax or mail to: Oklahoma State Department of Health, Newborn Screening Program Coordinator, 1000 NE Tenth Street, Oklahoma City, OK 73117-1299, (405) 271-6617 or 1-800-766-2223; Fax (405) 271-4892.

[OAR Docket #07-1416; filed 10-5-07]

Emergency Adoptions

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-1407]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
317:30-3-59. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 8. Rehabilitation Hospitals
317:30-5-111. [AMENDED]
Part 27. ~~Registered~~ Independent Licensed Physical Therapists
317:30-5-290. [AMENDED]
(Reference APA WF # 07-30)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.110; 42 CFR 440.20

DATES:

Adoption:

August 15, 2007

Approved by Governor:

Septmeber 12, 2007

Effective:

Immediately upon Governor's approval or October 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions which will provide needed clarity for SoonerCare providers when billing for therapy services for adults. Revisions will remove inconsistencies in rules for payment of adult therapies in the inpatient and outpatient hospital settings in an effort to increase the accuracy of SoonerCare claims.

ANALYSIS:

Agency rules are revised to remove inconsistencies in rules for payment of adult therapies in the inpatient and outpatient hospital settings. Therapy services for adult SoonerCare members are only compensable when provided on an inpatient or outpatient hospital basis. In addition, language regarding the post-payment utilization review conducted by the OHCA's designated Quality Improvement Organization is updated to reflect current practice. Revisions are needed to clarify the rules used by SoonerCare providers who provide therapy services to adults in the inpatient and outpatient hospital settings.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR OCTOBER 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-59. General program exclusions - adults

The following are excluded from ~~Medicaid~~ SoonerCare coverage for adults:

- (1) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (2) Services or any expense incurred for cosmetic surgery.
- (3) Services of two physicians for the same type of service to the same patient at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the patient's care, the codes for subsequent hospital care should be used.
- (4) Refractions and visual aids.
- (5) ~~Separate A separate~~ payment for ~~pre and post-operative care when payment is made for surgery pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.~~
- (6) Reversal of sterilization procedures for the purposes of conception.
- (7) Non therapeutic hysterectomies. Therapeutic hysterectomies require that the following information to be attached to the claim:
 - (A) a copy of an acceptable acknowledgment form signed by the patient, or,
 - (B) an acknowledgment by the physician that the patient has already been rendered sterile, or,
 - (C) a physician's certification that the hysterectomy was performed under a life-threatening emergency situation.
- (8) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest.
- (9) Medical services considered to be experimental.
- (10) Services of a Certified Surgical Assistant.
- (11) Services of a Chiropractor. Payment is made for Chiropractor services on Crossover claims for coinsurance and/or deductible only.
- (12) Services of a ~~Registered~~ an independent licensed Physical Therapist.
- (13) Services of a Psychologist.
- (14) Services of a an independent licensed Speech and Hearing Therapist.
- (15) Payment for more than four outpatient visits per month (home, office, outpatient hospital) per patient,

except those visits in connection with family planning or emergency medical condition.

- (16) Payment for more than two nursing home visits per month.
- (17) More than one inpatient visit per day per physician.
- (18) Payment for removal of benign skin lesions unless medically necessary.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 8. REHABILITATION HOSPITALS

317:30-5-111. Coverage for adults

For persons 21 years of age or older, payment is made to hospitals for inpatient services as described in this section.

- (1) All general inpatient hospital services which are not provided under the Diagnosis Related Group (DRG) payment methodology for all persons 21 years of age or older is limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limitation applies to both hospital and physician services. No exceptions or extensions will be made to the 24 day inpatient services limitation.
- (2) All inpatient ~~services stays~~ are subject to post-payment utilization review by the ~~Oklahoma Health Care Authority, or its OHCA's~~ designated agent Quality Improvement Organization (QIO). These reviews ~~will be~~ are based on ~~OHCA's, or its designated agent's, admission criteria on~~ severity of illness and intensity of treatment.

(A) It is the policy and intent of OHCA to allow hospitals and physicians the opportunity to present any and all documentation available to support the medical necessity of an admission and/or extended stay of a Medicaid SoonerCare recipient member. If the ~~OHCA, or its designated agent QIO,~~ upon their initial review determines the admission should be denied, a notice is ~~sent~~ issued to the facility and the attending ~~physician(s) physician~~ advising them of the decision. This notice also advises that a reconsideration request may be submitted within ~~60 days~~ the specified time frame on the notice and consistent with the Medicare guidelines. Additional information submitted with the reconsideration request ~~will be~~ is reviewed by the ~~OHCA, or its designated agent, who QIO~~ that utilizes an independent physician advisor. If the denial decision is upheld through this review of additional information, ~~OHCA is informed. At that point, OHCA the QIO~~ sends a letter written notification of the denial decision to the hospital, ~~and attending physician requesting refund of the Medicaid payment previously made on the denied~~

~~admission and the OHCA. Once the OHCA has been notified, the overpayment is processed as per the final denial determination.~~

(B) If the hospital or attending physician did not request reconsideration ~~by the OHCA, or its designated agent from the QIO, the OHCA, or its designated agent, QIO~~ informs OHCA that there has been no request for reconsideration and as a result their initial denial decision is final. OHCA, in turn, ~~sends a letter to the hospital and physician requesting refund of the amount of Medicaid payment previously made on the denied admission processes the overpayment as per the denial notice sent to the OHCA by the QIO.~~

(C) If an OHCA, or its designated agent, review results in denial and the denial is upheld throughout the appeal process and refund from the hospital and physician is required, the Medicaid recipient member cannot be billed for the denied services.

(3) If a hospital or physician believes that a hospital admission or continued stay is not medically necessary and thus not Medicaid compensable but the patient member insists on treatment, the patient member should be informed that he/she will be personally responsible for all charges. If a Medicaid claim is filed and paid and the service is later denied, the patient is not responsible. ~~If a Medicaid claim is not filed and paid, the patient can be billed.~~

(4) Payment is made to a participating hospital for hospital based physician's services. The hospital must have a Hospital-Based Physician's contract with OHCA for this method of billing.

(5) Outpatient services for adults are covered as listed in OAC 317:30-5-42.1.

PART 27. REGISTERED INDEPENDENT LICENSED PHYSICAL THERAPISTS

317:30-5-290. Payment for outpatient services [REVOKED]

~~Payment is made for compensable services to the individual physical therapist for outpatient services. Payment for inpatient services provided by a registered licensed physical therapist is included in the hospital's per diem rate.~~

- ~~(1) In order to be eligible for payment, the licensed physical therapist must have a current Provider Agreement on file with this the Authority.~~
- ~~(2) Claims should be filed using the appropriate HCPCS procedure codes which are included in the HCPCS Supplemental Coding book which is maintained by the local Medicare Carrier.~~

[OAR Docket #07-1407; filed 9-26-07]

Emergency Adoptions

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-1411]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 1. Physicians

317:30-5-2. [AMENDED]

317:30-5-18. [AMENDED]

Part 63. Ambulatory Surgical Centers

317:30-5-568. [AMENDED]

(Reference APA WF # 07-02)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR §50.205, 42 CFR §50.209, and 42 CFR §50.210

DATES:

Adoption:

July 12, 2007

Approved by Governor:

August 16, 2007

Effective:

Immediately upon Governor's approval or September 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to ease the administrative burden on providers by allowing them to use any form that is federally approved for sterilization consent.

ANALYSIS:

Agency rules are revised to allow providers to use any form that is federally approved for sterilization consent. Current rules require providers to submit the OHCA ADM-71 form for sterilization consent in order to receive SoonerCare payment for the sterilization procedure. Providers who perform sterilization procedures funded through federally assisted public health programs such as Indian health facilities are required to submit a federal sterilization consent form to obtain federal reimbursement in addition to the OHCA ADM-71 for SoonerCare payment. Indian Health Services (IHS) providers have reported that the requirement to use both the federal sterilization form and the OHCA sterilization form causes confusion among SoonerCare members and IHS staff and results in denied SoonerCare claims for not submitting the appropriate form. By eliminating the requirement of a specific sterilization form to be used and allowing providers to use any federally approved form, providers will be in compliance with both OHCA rules and federal regulations without duplicate administrative effort.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR SEPTEMBER 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-2. General coverage by category

(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) medical programs, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.

(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.

(B) Inpatient psychotherapy by a physician.

(C) Inpatient psychological testing by a physician.

(D) One inpatient visit per day, per physician.

(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgical center or a Medicare certified hospital that offers outpatient surgical services. Refer to the List of Covered Surgical Procedures.

(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.

(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.

(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare patient, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".

(I) Diagnostic x-ray and laboratory services.

(J) Mammography screening and additional follow-up mammograms.

(K) Obstetrical care.

(L) Pacemakers and prostheses inserted during the course of a surgical procedure.

(M) Prior authorized examinations for the purpose of determining medical eligibility for programs under the jurisdiction of the Authority. A copy of the authorization, OKDHS form ABCDM-16, Authorization

for Examination and Billing, must accompany the claim.

(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.

(O) Family planning - includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and, executes the federally mandated consent form (~~ADM-71~~) with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for I.U.D. insertion during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.

(P) Genetic counseling (requires special medical review prior to approval).

(Q) Weekly blood counts for members receiving the drug Clozaril.

(R) Complete blood count (CBC) and platelet count prior to receiving chemotherapeutic agents, radiation therapy or medication such as DPA-D-Penicillamine on a regular basis for treatment other than for malignancy.

(S) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(T) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.

(U) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:

- (i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;
- (ii) Board certification or completion of an accredited residency program in the fellowship specialty area;
- (iii) Hold unrestricted license to practice medicine in Oklahoma;
- (iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;
- (v) Seeing members without supervision;
- (vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;
- (vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.
- (viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within

the context of their primary specialty and only to the extent as allowed by their accrediting body.

(V) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.

- (i) Attending physician performs chart review and sign off on the billed encounter;
- (ii) Attending physician present in the clinic/or hospital setting and available for consultation;
- (iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.

(W) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:

- (i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;
- (ii) The contact must be documented in the medical record.

(X) Payment to a physician for supervision of CRNA services unless the CRNA bills directly.

(Y) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.

(Z) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:

- (i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
- (ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
- (iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
- (iv) Procedures considered experimental or investigational are not covered.

(AA) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

- (i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.
- (ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(BB) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(CC) Ventilator equipment.

(DD) Home dialysis equipment and supplies.

Emergency Adoptions

(EE) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB not listed in OAC 317:30-3-46 require prior authorization by the College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(FF) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.

(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:

- (I) Asking the member to describe their smoking use;
- (II) Advising the member to quit;
- (III) Assessing the willingness of the member to quit;
- (IV) Assisting the member with referrals and plans to quit; and
- (V) Arranging for follow-up.

(ii) Up to eight sessions are covered per year per individual.

(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, nurse practitioners, nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP capitation payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.

(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(GG) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

(A) Inpatient diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising

on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the procedure codes for subsequent hospital care must be used.

(D) Refractions and visual aids.

(E) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomy.

(I) Medical services considered to be experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member except those visits in connection with family planning, or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician supervision of hemodialysis or peritoneal dialysis.

(N) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Payment for the services of physicians' assistants, social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(Q) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury, or illness related to a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(R) Night calls or unusual hours.

(S) Speech and Hearing services.

(T) Mileage.

(U) A routine hospital visit on the date of discharge unless the member expired.

(V) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(W) Inpatient chemical dependency treatment.

(X) Fertility treatment.

- (Y) Payment for removal of benign skin lesions unless medically necessary.
- (b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's medical programs, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. In addition to those services listed for adults, the following services are covered for children.
- (1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not ~~be~~ SoonerCare compensable.
 - (A) Effective October 1, 1993, all residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25, 317:30-5-95.27 and 317:30-5-95.29.
 - (B) Out of state placements will not be authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements will be proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.
 - (2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.
 - (3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.
 - (4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.
 - (5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis,

and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law, Title 21, Oklahoma Statutes, Section 846, as amended, states in part: *Every physician or surgeon, including doctors of medicine and dentistry, licensed osteopathic physicians, residents, and interns, examining, attending, or treating a child under the age of eighteen (18) years and every registered nurse examining, attending or treating such a child in the absence of a physician or surgeon, and every other person having reason to believe that a child under the age of eighteen (18) years has had physical injury or injuries inflicted upon him or her by other than accidental means where the injury appears to have been caused as a result of physical abuse or neglect, shall report the matter promptly to the county office of the Department of Human Services in the county wherein the suspected injury occurred. Providing it shall be a misdemeanor for any person to knowingly and willfully fail to promptly report an incident as provided above. Persons reporting such incidents of abuse and/or neglect in accordance with the law are exempt from prosecution in civil or criminal suits that might be brought as a result of the report.*

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

- (A) Inpatient diagnostic studies that could be performed on an outpatient basis.
- (B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.
- (C) Services of two physicians for the same type of service to the same member at the same time, except when warranted by the necessity of supplemental skills. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the member's care, the codes for subsequent hospital care must be used.
- (D) A separate payment for pre-operative care, if provided on the day before or the day of surgery, or for typical post-operative follow-up care.
- (E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.
- (F) Sterilization of persons who are under 21 years of age.
- (G) Non-therapeutic hysterectomy.

Emergency Adoptions

(H) Medical Services considered to be experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician supervision of hemodialysis or peritoneal dialysis.

(L) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board, dictation, and similar functions.

(M) Payment for the services of physicians' assistants except as specifically set out in OHCA rules.

(N) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(O) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(P) Night calls or unusual hours.

(Q) Mileage.

(R) A routine hospital visit on date of discharge unless the member expired.

(S) Tympanometry.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. For in-State physicians, claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment in order to be considered timely filed. The Medicare EOMB must be attached to the claim. If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare".

(1) Out of state claims will not "cross over". Providers must file a claim for coinsurance and/or deductible within 90 days of the Medicare payment. The Medicare EOMB must be attached to the claim.

(2) Claims filed under SoonerCare must be filed within one year from the date of service. For dually eligible members, to be eligible for payment of coinsurance and/or deductible under SoonerCare, a claim must be filed with Medicare within one year from the date of service.

317:30-5-18. Elective sterilizations

(a) Payment is made for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:

(1) The patient must be at least 21 years of age at the time the consent form is signed;

(2) The patient must be mentally competent, and not presently institutionalized;

(3) A properly completed ~~Federally~~ federally mandated consent for sterilization form is attached to the claim; and

(4) The form is signed and dated at least 30 days, but not more than 180 days prior to surgery.

(b) When a sterilization procedure is performed in conjunction with a C-Section, the appropriate HCPC coding is used to report the procedures performed. A consent form is required when the sterilization procedure is performed.

(c) Reversal of sterilization procedures for the purpose of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim.

~~(d) The ADM 71 consent form was developed to meet federal requirements.~~

PART 63. AMBULATORY SURGICAL CENTERS

317:30-5-568. Elective sterilizations

Payment is made to ambulatory surgical centers for elective sterilizations performed in behalf of eligible individuals if all of the following circumstances are met:

(1) The patient must be at least 21 years of age at the time the consent form is signed,

(2) The patient must be mentally competent,

(3) A properly completed ~~Federally~~ federally mandated consent for sterilization form (~~ADM 71~~) is attached to the claim, and

(4) The form is signed and dated at least 30 days, but not more than 180 days prior to surgery. ~~A supply of the form (ADM 71) can be obtained from the local Department of Human Services county office.~~

[OAR Docket #07-1411; filed 9-26-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-1409]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 5. Pharmacies

317:30-5-70.2. [AMENDED]

(Reference APA WF # 07-44)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 110-28 known as the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007

DATES:

Adoption:

August 15, 2007

Approved by Governor:

September 12, 2007

Effective:

Immediately upon Governor's approval or October 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with Public Law 110-28 known as the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 which requires that all prescription drugs in written form be executed on tamper-resistant prescription pads in order to qualify for reimbursement under federal Medicaid guidelines. Rule revisions are necessary since federal financial participation will not be available for written prescriptions for SoonerCare members on or after October 1, 2007, that are not written on tamper-resistant prescription pads.

ANALYSIS:

Agency rules are revised to comply with Public Law 110-28 known as the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 requiring prescriptions in written form to be executed on tamper-resistant prescriptions pads in order to qualify for reimbursement by SoonerCare. Currently, there is no rule in place to require certain types of paper for prescriptions. This federal requirement mandates that written prescriptions be printed on certain types of paper which cannot be copied. The requirement does not apply to prescriptions transmitted by telephone, facsimile, or electronic prescribing. Effective October 1, 2007, federal financial participation will not be available for written prescriptions to SoonerCare members that are not written on tamper-resistant prescription pads.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR OCTOBER 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-70.2. Record retention/ Post Payment Review

Post-payment audits of the SoonerCare program are performed routinely by state and federal agencies. This Section applies to any post-payment audit regardless of the agency performing the audit. Pharmacies are selected at random for audits. The Pharmacy is required to provide original written prescriptions and signature logs as well as purchase invoices and other records necessary to document their compliance with

program guidelines at the time of the audit. Written prescriptions must conform with the standards set forth in 42 USC 1396b(i) and related federal regulations requiring the use of a tamper-resistant prescription pad. These standards do not apply to prescriptions transmitted via telephone, facsimile or electronic prescription systems. Original written prescriptions are defined as any order for drug or medical supplies written or signed, or transmitted by word of mouth, telephone or other means of communication by a practitioner licensed by law to prescribe such drugs and medical supplies intended to be filled, compounded, or dispensed by a pharmacist. Signature logs are defined as any document which verifies that the prescription was delivered to the member or their representative. This may include electronic forms of tracking including but not limited to scanning a bar code of the filled prescription. The electronic tracking system must be able to produce a copy of the scan for audit purposes. Failure to provide the requested information to the Authority Reviewer may result in a recommendation ranging from a potential recoupment of Medicaid SoonerCare payments for the service to contract termination.

[OAR Docket #07-1409; filed 9-26-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

[OAR Docket #07-1412]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 5. ~~Pharmacists~~Pharmacies

317:30-5-72.1. [AMENDED]

(Reference APA WF # 07-06)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR §440.120

DATES:

Adoption:

June 14, 2007

Approved by Governor:

July 27, 2007

Effective:

Immediately upon Governor's approval or August 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to allow coverage of certain non-prescription medications when they are used as part of a step therapy or other therapeutic algorithm. Rule revisions allow the use of less toxic and less expensive non-prescription products and often reduce the need for a physician visit. For example, one of the many intended benefits of the rule revisions will specifically allow SoonerCare payment for non-prescription medications used

Emergency Adoptions

to treat head lice. If the family did not have funds for the over-the-counter product, they would have to see a physician for a prescription resulting in the use of a more costly and toxic product.

ANALYSIS:

Agency rules are revised to update drug categories that are covered under SoonerCare as well as drug categories that are excluded or subject to limitations. Rules are also revised to allow coverage of certain non-prescription medications when they are used as part of a step therapy or other therapeutic algorithm. For example, current SoonerCare rules do not allow coverage for over-the-counter products used to treat lice infestation of the hair or body. This may require a physician visit in addition to a more toxic and expensive prescription product. One of the many intended benefits of the rule revisions will specifically allow SoonerCare payment for non-prescription medications used to treat head lice. Revisions are needed to allow SoonerCare members access to certain over-the-counter products as well as appropriate drug categories.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACISTS PHARMACIES

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 Authority OHCA covers ~~any~~ a drug for its approved purpose that has been approved by the Food and Drug Administration (FDA) ~~and whose~~ for manufacturers ~~who~~ have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), ~~formerly known as the Health Care Financing Administration (HCFA)~~ 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 for the symptomatic relief of coughs and colds. Cough and cold drugs are not covered.~~
 - ~~(E) Vitamins and Minerals.~~
 - ~~(F) 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.~~
 - ~~(G) Agents used for smoking cessation. Nicotine replacement products are not covered.~~
 - ~~(H) Food supplements.~~

~~(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.~~

~~(K) Over the counter drugs. Over the counter medications are not covered except for those medications listed in Paragraph (3) of this subsection.~~

(2) ~~The exceptions to the exclusions provided in subsection OAC 317:30-5-72.1(1) are as follows~~ 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; and
- (iii) ~~calcifediol/calciferol~~ vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered.

~~(C) Agents used primarily for the treatment of anorexia or weight gain. There is limited coverage under the scope based prior authorization.~~

~~(D) Agents used for smoking cessation. A limited smoking cessation benefit is available through OAC 317:30-5-77.2(e)(1)(B)(ii).~~

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

- ~~(i) Insulin, PKU formula and amino acid bars,~~
- ~~(ii) certain smoking cessation products, and the following~~
- ~~(iii) family planning products, and are covered.~~
- ~~(i) Male and Female Condoms.~~
- ~~(ii) Contraceptive sponges.~~
- ~~(iii) Diaphragms.~~
- ~~(iv) Spermicidal jellies, creams, suppositories, and foams.~~
- ~~(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate.~~

~~(E) Coverage of food supplements is limited to Phenylketonuria (PKU) formula and amino acid bars for members diagnosed with PKU.~~

(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 ~~the Health Care Financing Administration; CMS.~~
 - ~~(C) OHCA has excluded coverage of the drug from its formulary established by the State as provided under 42 U.S.C. § 1396r-8.~~

[OAR Docket #07-1412; filed 9-26-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE
FOR SERVICE**

[OAR Docket #07-1403]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
317:30-5-9. [AMENDED]
317:30-5-20. [AMENDED]
(Reference APA WF # 07-15)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR '440.30; 42 CFR '440.50

DATES:

Adoption:

June 14, 2007

Approved by Governor:

July 27, 2007

Effective:

Immediately upon Governor's approval or August 1,2007, whichever is later.

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATION BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rules to eliminate the potential for improper billing and reimbursement for venipuncture and catheterization procedures.

ANALYSIS:

Physician rules are revised to eliminate the potential for improper billing and reimbursement for venipuncture and catheterization by clarifying that a separate payment is made to physicians for specimen collections using catheterization and routine venipuncture. In addition, a revision of Laboratory services rules is needed to clarify that a separate payment is not made to laboratories for specimens obtained as it is considered part of the laboratory analysis. A Surveillance Utilization Review System (SURS) audit discovered the contradiction. These revisions are needed to clarify that these are allowable separate reimbursements for physicians in their offices but not for laboratories. If this is not changed, there is potential for improper billing or reimbursement based on inconsistency in the rule and how the rule is interpreted. Additional revisions revise language to agree with current SoonerCare language.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR AUGUST 1, 2007, WHICHEVER IS LATER:

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS
AND SPECIALTIES**

PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

- (1) Payment is made for four office visits (or home) per month per ~~patient~~ member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.
- (2) Visits for the purpose of family planning are excluded from the four per month limitation.
- (3) Payment is allowed for insertion of IUD in addition to the office visit.
- (4) Separate payment will be made for the following supplies when furnished during a physician's office visit.
 - (A) Casting materials
 - (B) Dressing for burns
 - (C) Intrauterine device
 - (D) IV Fluids
 - (E) Medications administered by IV
 - (F) Glucose administered IV in connection with chemotherapy in office
- (5) Payment is made for routine physical exams only as prior authorized by the ~~County DHS office~~ OKDHS and are not counted as an office visit.
- (6) Medically necessary office lab and X-rays are covered.
- (7) Hearing exams by physician for ~~persons~~ members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.
- (8) Hearing aid evaluations are covered for ~~persons~~ members under 21 years of age.
- (9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.
- (10) Payment is made for both office visit and injection of joints performed during the visit.
- (11) Payment is made for an office visit in addition to allergy testing.
- (12) Separate payment is made for antigen.

Emergency Adoptions

- (13) Eye exams are covered for ~~persons~~ members between ages 21 and 65 for medical diagnosis only.
- (14) If a physician personally sees a ~~patient~~ member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.
- (15) ~~Separate payment is made for The the~~ following specimen ~~collection fees are covered~~ collections:
- (A) ~~Catheterization for collection of specimen, multiple patients.~~
 - (B) A Catheterization for collection of specimen, ~~single patient member, all places of service.; and~~
 - (C) B Routine Venipuncture.
- (16) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.
- (17) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.
- (c) **Non-covered office services.**
- (1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.
 - (2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.
 - (3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.
 - (4) Additional payment will not be made for night calls, unusual hours or mileage.
 - (5) Payment is not made for an office visit where the ~~patient~~ member did not keep appointment.
 - (6) Refractive services are not covered for persons between the ages of 21 and 65.
 - (7) Removal of stitches is considered part of post-operative care.
 - (8) Payment is not made for a consultation in the office when the physician also bills for surgery.
 - (9) Separate payment is not made for oxygen administered during an office visit.
- (d) **Covered inpatient medical services.**
- (1) ~~For persons between ages 21 and 65, payment is made for 24 days hospital care per state fiscal year. For persons under 21 years of age, payment is made for medically necessary inpatient care. Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions.~~ Psychiatric admissions must be prior authorized.
 - (2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved. When supplemental skills are warranted, the initial consultation is reported utilizing the appropriate CPT code for inpatient consultations. Follow-up consultations include monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the ~~patient's~~
- member's status. If the consultant physician initiates treatment at the initial consultation and participates thereafter in the ~~patient's~~ member's care, the codes for subsequent hospital care ~~should be~~ are used.
- (3) Certain medical procedures are allowed in addition to office visits.
- (4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day and 4 units per month. Payment for critical care, each additional 30 minutes is limited to two units per day/month.
- (e) **Non-covered inpatient medical services.**
- (1) For inpatient services, all visits to a ~~patient~~ member on a single day are considered one service except where specified. Payment is made for only one visit per day.
 - (2) A hospital ~~admit~~ admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.
 - (3) Drugs administered to inpatients are included in the hospital payment.
 - (4) Payment will not be made to a physician for an admission or new patient work-up when ~~patient~~ the member receives surgery in out-patient surgery or ambulatory surgery center.
 - (5) Payment is not made to the attending physician for interpretation of tests on his own patient.
- (f) **Other medical services.**
- (1) Payment will be made to physicians providing Emergency Department services.
 - (2) Payment is made for two nursing home visits per month. The appropriate CPT code ~~should be~~ is used.
 - (3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.
 - (4) When the physician bills twice for the same procedure on the same day, it ~~should~~ must be supported by a written report.
- 317:30-5-20. Laboratory services**
- This Section covers the guidelines for payment of laboratory services by a ~~physician~~ provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.
- (1) **Covered lab services.** ~~Physicians~~ Providers may be paid for covered clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a ~~physician~~ provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.
- (A) Effective September 1, 1992, reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those

furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from HCFA and have a current contract on file with this Authority the OHCA. Payment is made only for those services which fall within the approved specialties/subspecialties.

(B) Effective May 1, 1993, reimbursement rate for laboratory procedures is the lesser of the HCFA National 60% fee or the local carrier's allowable (whichever is lower).

(C) All claims for laboratory services are considered medically necessary unless specifically disallowed in this Chapter.

(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered. Genetic counseling requires special medical review prior to approval.

(3) **Noncompensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected ~~through catheterization by a laboratory.~~ These services are considered part of the ~~physician's office visit laboratory analysis. The exception to this limitation is for specimens for lead screenings for children under EPSDT. Payment will be made to the lab under the appropriate procedure code for obtaining specimen.~~

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital ~~per diem~~ rate.

(4) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen. The appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

(5) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Tissue examinations for identification of teeth and foreign objects.

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

[OAR Docket #07-1403; filed 9-26-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

[OAR Docket #07-1405]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 5. Individual Providers and Specialties

- Part 27. Registered Physical Therapists
317:30-5-290. [AMENDED]
317:30-5-290.1. [NEW]
317:30-5-291. [AMENDED]
317:30-5-291.1. through 317:30-5-291.2. [NEW]
Part 28. Occupational Therapy Services [NEW]
317:30-5-295. through 317:30-5-298. [NEW]
(Reference APA WF # 07-23)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.110

DATES:

Adoption:

June 14, 2007

Approved by Governor:

July 27, 2007

Effective:

Immediately upon Governor's approval or August 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to remove a barrier to the delivery of necessary physical therapy services to children.

ANALYSIS:

Agency rules are revised to remove the prior authorization requirement for the initial evaluation for physical therapy services for children. Currently, rules state that all physical therapy services, including the initial evaluation, for children must be prior authorized. As an evaluation is needed to determine if therapy services are medically necessary and compensable, provider prior authorization requests for an evaluation are routinely approved. By removing the prior authorization requirement, children will be able to more promptly receive needed services. Provider specific rules for outpatient occupational therapy services are issued to consolidate information regarding payment for services, provider eligibility, coverage, payment rates and procedure codes. Rules regarding speech therapy for children are revised to clarify prior authorization requirements.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 27. REGISTERED PHYSICAL THERAPISTS

317:30-5-290. Payment for outpatient services

Payment is made for compensable services to the individual physical therapist for outpatient services. Payment for

Emergency Adoptions

inpatient services provided by a registered physical therapist is included in the hospital's per diem rate.

- (1) In order to be eligible for payment, the ~~RPT licensed physical therapist~~ must have a current ~~Memorandum of Provider Agreement~~ on file with this Authority.
- (2) Claims should be filed using the appropriate HCPCS procedure codes which are included in the HCPCS Supplemental Coding book which is maintained by the local Medicare Carrier.

317:30-5-290.1. Eligible providers

- (a) Eligible physical therapists must be appropriately licensed in the state in which they practice.
- (b) All eligible providers of physical therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform physical therapy services.

317:30-5-291. Coverage by category

Payment is made to registered physical ~~therapist's therapists~~ as set forth in this Section

- (1) ~~Children. Coverage for children is as authorized.~~ Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service.
- (2) ~~Adults. There is no coverage for adults.~~
- (3) ~~Individuals eligible for Part B of Medicare. Payment is made utilizing the Medicaid allowable for comparable services.~~ Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

317:30-5-291.1. Payment rates

Payment is made in accordance with the current allowable Medicaid fee schedule.

317:30-5-291.2. Procedure codes

The appropriate procedure codes used for billing physical therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

PART 28. OCCUPATIONAL THERAPY SERVICES

317:30-5-295. Eligible Providers

- (a) Eligible occupational therapists must be appropriately licensed in the state in which they practice.
- (b) All eligible providers of occupational therapy services must have entered into a Provider Agreement with the Oklahoma Health Care Authority to perform occupational therapy services.

317:30-5-296. Coverage by category

Payment is made for occupational therapy services as set forth in this Section.

- (1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service.
- (2) **Adults.** There is no coverage for adults.
- (3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

317:30-5-297. Payment rates

Payment is made in accordance with the current allowable Medicaid fee schedule.

317:30-5-298. Procedure codes

The appropriate procedure codes used for billing occupational therapy services are found in the Physicians' Current Procedural Terminology (CPT) Coding Manual.

[OAR Docket #07-1405; filed 9-26-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-1406]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties
Part 43. ~~Adult Agency Companion, Specialized Foster Care, Daily Living Supports, Group Homes, and Community Transition Services~~
317:30-5-420. through 317:30-5-424. [AMENDED]
(Reference APA WF # 07-28)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

DATES:

Adoption:

August 15, 2007

Approved by Governor:

September 12, 2007

Effective:

Immediately upon Governor's approval or October 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to facilitate consistency with the Home and Community-Based Services Waivers which were approved by the Centers for Medicare and Medicaid effective July 1, 2007. The United States Supreme Court's decision in *Olmstead vs. L.C.* requires that Oklahoma provide service options to enable individuals with disabilities to live in the community rather than receiving services in an institution. These revisions will allow more individuals the opportunity and means to make that transition.

ANALYSIS:

Agency rules are revised to: (1) reflect current residential support options through the OKDHS Developmental Disabilities Services Division (DDSD) Home and HCBS Waiver program as approved by CMS; and (2) provide a new residential support option known as Community Transition Services. On April 25, 2007, the Centers for Medicare and Medicaid approved an amendment to Oklahoma's Community Waiver which added Community Transition Services to the waiver program. The revisions will provide Oklahomans with disabilities additional community-based service options. Community Transition Service is a one-time setup expense for members transitioning from an intermediate care facility for the mentally retarded or provider-operated residential setting to the member's own home or apartment. Limited to one service over the member's lifetime, Community Transition Service's maximum benefit is \$2,400 per eligible member and must be authorized in the member's Individual Plan. Rule revisions are needed to support recent amendments to Oklahoma's Community Waiver and allow payment for Community Transition Services.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR OCTOBER 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 43. ADULT AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, AND COMMUNITY TRANSITION SERVICES

317:30-5-420. Introduction to waiver services and eligible providers Home and Community-Based Services Waivers for persons with mental retardation or certain persons with related conditions

(a) **Introduction to waiver services.** The Oklahoma Health Care Authority (OHCA) administers ~~two home and community based waivers for services to individuals Home and Community-Based Services (HCBS) Waivers for persons with mental retardation or and certain persons with related conditions that are operated by the Oklahoma Department of Human Services Developmental Disabilities Services Division (DDSD). Both waivers are enacted under Section 1915(e) of the Social Security Act. Each waiver allows The Community Waiver and Homeward Bound Waiver allow payment for services provided to eligible individuals that are not covered through Oklahoma's Medicaid program residential supports as defined in the waiver approved by the Centers for Medicare and Medicaid Services (CMS). Waiver services, when utilized with services normally covered by Medicaid, provide for health and developmental needs of individuals who otherwise would not be able to live in a home or community setting. The first waiver, implemented in 1988, provides home and community based services for mentally retarded individuals who otherwise require the level of~~

~~care in an Intermediate Care Facility for the Mentally Retarded. The second waiver, implemented in 1991, provides home and community based services to persons with mental retardation or related conditions who are inappropriately placed in nursing facilities. The specific services provided are the same in each waiver and may only be provided to Medicaid eligible individuals outside of a nursing facility. Any waiver service should be appropriate to the client's needs and must be written on the client's Individual Habilitation Plan (IHP). The IHP is developed annually by an interdisciplinary team (IDT). The IHP contains detailed descriptions of services provided, documentation of frequency of services and types of providers to provide services.~~

(b) **Eligible providers.** All Adult Companion Service providers must have entered into contractual agreements (MA S 342) with the Oklahoma Health Care Authority to supply Home and Community Based Waiver Services (HCBWS) for the Mentally Retarded. Adult Companion Service providers must complete the Developmental Disabilities Services Division (DDSD) sanctioned Direct Contact Training curriculum in accordance with the schedule authorized by DDSD.

317:30-5-421. Coverage

All Adult Companion Services will Residential supports must be included in the IHP and reflected in the approved plan of care member's Individual Plan (IP). Arrangements for care under this program will must be made through the individual client's member's case manager.

317:30-5-422. Description of services

Adult Companion Service is an individualized living arrangement offering 24 hour per day supervision, peer companionship, supportive assistance and training in daily living skills, lodging and nourishment to eligible individuals 18 and older. Services are provided to one to three recipients in the home in which the service provider resides or in the beneficiary's home. Three levels of adult companion service, based upon the service recipient's level of need as determined by an interdisciplinary team, are recognized Residential supports include:

- (1) Maximum supervision for those individuals with extensive needs agency companion services (ACS) provided in accordance with Part 1 of OAC 317:40-5;
- (2) Close supervision for those individuals with moderate needs; and specialized foster care (SFC) provided in accordance with Part 5 of OAC 317:40-5;
- (3) Intermittent supervision for those individuals with minimum needs: daily living supports (DLS) provided in:
 - (A) Community Waiver in accordance with OAC 317:40-5-150; and
 - (B) Homeward Bound Waiver in accordance with OAC 317:40-5-153;
- (4) group home services provided in accordance with OAC 317:40-5-152; and
- (5) community transition services (CTS).
 - (A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma

Emergency Adoptions

Health Care Authority (OHCA) to provide ACS, habilitation training specialist (HTS) services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for the mentally retarded (ICF/MR) or provider-operated residential setting to the member's own home or apartment. CTS:

(i) is furnished only when the member is unable to meet such expense and must be authorized in the member's Individual Plan (IP);

(ii) includes security deposits, essential furnishings, setup fees or deposits for utility or service access, including phone, electricity, gas, and water, moving expenses, and services necessary for the member's health and safety. Utilities must be in the members's name; and

(iii) does not include:

(I) recreational items, such as television, cable television access, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, or computer used primarily as diversion or recreation; and

(II) monthly rental or mortgage expense, food, or regular utility charges.

317:30-5-423. Coverage limitations

(a) Payment rates and coverage Coverage limitations for adult companion services residential supports for the mentally retarded members with mental retardation are as follows:

(1) Description: Intermittent Supervision agency companion services (ACS); Unit: One one day; Limitation: 366 units per year;

(2) Description: specialized foster care (SFC); Unit: one day; Limitation: 366 units per year;

(2 3) Description: Close Supervision daily living supports (DLS); Unit: One one day; Limitation: 366 units per year; and

(3 4) Description: Maximum Supervision group home services; Unit: One one day; Limitation: 366 units per year.

(b) Members may not receive ACS, SFC, DLS and group home services at the same time.

(c) Community transition services (CTS) are limited to \$2,400 per eligible member.

(1) CTS is limited to one transition over the member's lifetime. If the member's situation changes after receipt of CTS and hospitalization or readmission to an intermediate care facility for the mentally retarded (ICF/MR) is necessary, CTS is not authorized upon transition back into the community.

(2) Members moving into a group home, SFC, or ACS arrangement in the companion's home are not eligible to receive CTS.

317:30-5-424. Diagnosis code

The ICD-9-CM ~~Diagnosis~~ diagnosis code for ~~Adult Companion Services residential supports~~ is 319 (~~Mental Retardation~~ mental retardation). This code must be entered in ~~Item field 21 on the HCFA-1500 Form CMS-1500.~~

[OAR Docket #07-1406; filed 9-26-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

[OAR Docket #07-1404]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Individual Providers and Specialties

Part 79. Dentists

317:30-5-698. [AMENDED]

(Reference APA WF # 07-18)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; CFR 42 § 440.100

DATES:

Adoption:

June 14, 2007

Approved by Governor:

July 27, 2007

Effective:

Immediately upon Governor's approval or August 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that an imminent peril to the preservation of the public health, safety, or welfare exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to accommodate special needs children by allowing prior authorization information to be submitted post-op rather than prior to surgery in the cases where members must be sedated in order to obtain necessary prior authorization information. This revision is needed so special needs children will not have to be unnecessarily sedated in order to obtain data for prior authorization.

ANALYSIS:

Revisions to Dental rules are needed to allow prior authorization information for periodontal scaling and root planing to be submitted post-op in cases where the member has special needs (certain forms of cancer, or behavioral or emotional challenges) and must be sedated in order to obtain needed requirements for the prior authorization. Currently, members with certain special needs require two appointments: one with sedation to obtain prior authorization data and once services are authorized, another appointment with sedation for the scaling and root planing. Without this revision, certain special needs children must undergo unnecessary sedation and SoonerCare must reimburse for an additional appointment and sedation service. Rules need to be revised to allow for prior authorization information to be submitted post-op for certain special needs children who require sedation in order to obtain the needed data.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-698. Services requiring prior authorization

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Emergency dental care is immediate service that must be provided to relieve the recipient member from pain due to an acute infection, swelling, trismus or trauma. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. Study models (where indicated), x-rays, six point periodontal charting, comprehensive treatment plan and narrative may be requested. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. X-rays must be mounted so that they are viewed from the front of the member. If required x-rays sent are copies, each film or print must be of good, readable quality and identified as to left and right sides. The film must clearly show the requested service area of interest. X-rays must be identified with member name, date, recipient member ID number, provider name, and provider number. X-rays must be placed together in an envelope and stapled to the submission form. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) Endodontics. Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics.

(A) Anterior root canals. This procedure is for members whom, by the provider's documentation, have a treatment plan requiring more than four anterior root canals and/or posterior endodontics. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are ~~not~~ no other missing teeth in the same arch requiring replacement, unless numbers 6, 11, 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA filling must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor.

(vi) An endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

(B) Posterior endodontics. The guidelines for this procedure are as follows:

(i) The provider should document that the client member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to minimally retain a crown due to lack of natural tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 24 months post completion.

(v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area.

(vi) Only ADA accepted filling materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) there are missing teeth in the same arch requiring replacement;

Emergency Adoptions

- (II) an opposing tooth has super erupted;
 - (III) loss of tooth space is one third or greater;
 - (IV) opposing second molars are involved; or
 - (V) the member has multiple teeth failing due to previous inadequate root canal therapy.
- (ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.
- (x) a single failing root canal is determined not medically necessary for re-treatment.
- (2) Cast metal crowns or ceramic-based crowns. This procedure is compensable for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded ~~(ICF/MR)~~ (ICF/MR) and who have been approved for ~~ICF/MR~~ (ICF/MR) level of care. Certain criteria and limitations apply.
- (A) The following conditions must exist for approval of this procedure.
- (i) The tooth must be fractured or decayed to such an extent to prevent proper cuspal or ~~incisal~~ incisal function.
 - (ii) The clinical crown is destroyed by the above elements by one-half or more.
 - (iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.
- (B) The conditions listed in ~~(A)(i)~~ (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays when a request is made for any type of crown.
- (C) Routine build-up(s) for authorized crowns are included in the fee for the crown.
- (D) A crown will not be approved if adequate tooth structure does not remain to establish ~~cleansable~~ cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.
- (E) Preformed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.
- (F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.
- (G) Full cast metal crowns are treatment of choice for all posterior teeth.
- (H) Provider is responsible for replacement or repair of cast crowns for 48 months post insertion.
- (3) Cast frame partial dentures. This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) Acrylic partial. This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth to be clasped. This appliance includes all necessary clasps and rests.

(5) Fixed cast non-precious metal or porcelain/metal bridges. Only members 17 through 20 years of age where the bite relationship precludes the use of an acrylic or cast frame partial denture are considered. Study models with narrative are required to substantiate need for fixed bridge(s). Members must have excellent oral hygiene documented in the requesting provider's records.

(6) Periodontal scaling and root planing. This procedure requires that 50% or more of the six point measurements be four millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires anesthesia and some soft tissue removal ~~occurs. Tooth planing is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism.~~ The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

(7) Additional prophylaxis. The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

- (A) dilantin hyperplasia;
- (B) cerebral palsy;
- (C) mental retardation;
- (D) juvenile periodontitis.

[OAR Docket #07-1404; filed 9-26-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

[OAR Docket #07-1410]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-8. [AMENDED]
Subchapter 7. Medical Services
Part 5. Determination of Eligibility for Medical Services
317:35-7-48. [AMENDED]
(Reference APA WF # 07-46)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 441.20

DATES:

Adoption:

August 15, 2007

Approved by Governor:

September 12, 2007

Effective:

Immediately upon Governor's approval or October 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to: (1) allow an applicant/member who wants Family Planning services only to enroll in SoonerPlan (Family Planning Waiver services) even if they may be otherwise eligible for SoonerCare; and (2) allow closure of SoonerPlan benefits when the applicant/member has had a sterilization procedure. Current rules do not address closure of eligibility for SoonerPlan members who have been sterilized. Policy also does not address or exclude the choice of enrolling only in SoonerPlan if the member is eligible for SoonerCare. Currently, when it appears an applicant may be otherwise eligible for SoonerCare, he/she is sent an application for SoonerCare. They are certified for Soonerplan but if the SoonerCare application is not returned, they are disenrolled from SoonerPlan. If revisions are not made, the applicant/member will not have an option to receive SoonerPlan services only, and a case record may not be closed for family planning services for a member who has received a sterilization procedure.

ANALYSIS:

Eligibility rules for the SoonerPlan Program (Family Planning Waiver services) are revised to: (1) allow an applicant/member who wants Family Planning services only to enroll in SoonerPlan even if they may be otherwise eligible for SoonerCare; and (2) allow closure of SoonerPlan benefits when the applicant/member has undergone a sterilization procedure. Current rules do not allow an applicant the choice of receiving family planning services only but requires them to apply for SoonerCare, the full scope of Medicaid benefits. Currently, when it appears an applicant may be otherwise eligible for SoonerCare, he/she is sent an application for SoonerCare. They are certified for SoonerPlan but if the SoonerCare application is not returned, they are disenrolled from SoonerPlan. Revisions are needed to allow member/applicants the choice of enrolling in family planning services only when they do not want the full scope of Medicaid. In addition, current rules do not provide a process for closure of family planning services when a member undergoes sterilization procedures. Revisions are needed to allow case closure when the member has undergone a sterilization procedure and is no longer in need of family planning services.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR OCTOBER 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

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

All uninsured women and men ages 19 and older, who have not undergone a sterilization procedure, 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 ~~SoonerCare~~ benefits are categorically related to the Family Planning Waiver Program. If eligible for SoonerCare benefits, the individual can choose to enroll only in the Family Planning Waiver Program with the option of applying for SoonerCare at any time.

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

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), and (4)~~ of this ~~Section~~ Subsection. 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 countable income is at or below 185% of the federal poverty level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1).

(2) ~~The individual is not otherwise~~ Individuals eligible for Medicaid SoonerCare- can choose to enroll only in the Family Planning Waiver Program with the option of applying for SoonerCare at any time.

(3) The individual is uninsured. Persons who have Medicare or creditable health insurance coverage are not eligible for the Family Planning Waiver program. A stand alone policy such as dental, vision or pharmacy is not considered creditable health insurance coverage.

(4) The individual has not undergone a sterilization procedure.

(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.

Emergency Adoptions

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

[OAR Docket #07-1410; filed 9-26-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

[OAR Docket #07-1413]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 5. Eligibility and Countable Income

Part 5. Countable Income and Resources

317:35-5-41. [AMENDED]

317:35-5-41.1. through 317:35-5-41.11. [NEW]

317:35-5-45. through 317:35-5-47. [AMENDED]

317:35-5-49. [AMENDED]

Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals

Part 2. Medicaid Recovery Program

317:35-9-15. [AMENDED]

Part 7. Determination of Financial Eligibility

317:35-9-65. [AMENDED]

317:35-9-68. [AMENDED]

Subchapter 17. ADvantage Waiver Services

317:35-17-9. [AMENDED]

317:35-17-11. [AMENDED]

Subchapter 19. Nursing Facility Services

317:35-19-4. [AMENDED]

317:35-19-19. [AMENDED]

317:35-19-21. [AMENDED]

(Reference APA WF # 07-24)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 109-171 Deficit Reduction Act of 2005

DATES:

Adoption:

June 14, 2007

Approved by Governor:

July 27, 2007

Effective:

Immediately upon Governor's approval or August 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rules to comply with Public Law 109-171, the Deficit Reduction Act of 2005 (DRA). The DRA requires tightening of eligibility rules in certain areas to help deter the abuse of sheltering assets in order to qualify for long-term care services provided by Medicaid. Without the implementation of these rules, individuals who possess adequate financial resources to pay for their long-term care services could continue to qualify for long-term care services provided by SoonerCare. Proposed revisions are necessary in order to ensure that individuals who justly qualify for long-term care services provided by SoonerCare are getting the services they need.

ANALYSIS:

Agency rules are revised to comply with Sections of Public Law 109-171, known as the Deficit Reduction Act of 2005 (DRA), regarding SoonerCare

eligibility for long-term care services. The DRA requires tightening of eligibility rules in certain areas to help deter the abuse of sheltering of assets in order to qualify for long-term care services provided by Medicaid. Section 6012 of the DRA requires a change in the disclosure and treatment of annuities purchased on or after February 8, 2006. Prior to the DRA, annuities were treated as exempt assets and no consideration of an individual's annuities held or recently transferred was given when determining eligibility for long-term care services provided by SoonerCare. Section 6014 of the DRA establishes an upper limit for the excluded value of a home when determining the value of an individual's assets for purposes of SoonerCare eligibility for long-term care services. An individual will not be eligible for nursing facility services or other long-term care services provided by SoonerCare if the equity interest in his or her home exceeds \$500,000. Prior to the DRA, the full value of any primary residence was disregarded when determining eligibility for long-term care services provided by SoonerCare. Section 6016(c) of the DRA requires that the definition of assets for purposes of determining SoonerCare eligibility include certain funds used to purchase a promissory note, loan or mortgage. Section 6016(d) of the DRA requires that the definition of assets for purposes of determining SoonerCare eligibility include any purchase of a life estate interest in another individual's home. Proposed revisions are needed to ensure federal financial participation through compliance with the DRA.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

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

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

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

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

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

(4) Only the resources of the child determined eligible for TEFRA are considered in determining eligibility.

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

(6) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The member may change the form of capital resources from time to time without affecting eligibility so long as the equity is not decreased in doing so or increased in excess of the allowable maximum reserve resource standard. In the event the equity is decreased as the result of a sale or transfer, the reduction in the equity is evaluated in relation to policy applicable to resources disposed of while receiving assistance.

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

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

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

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

(4) The major types of capital resources are listed in (e) and (d) of this Section Sections OAC 317:35-5-41.1 through 317:35-5-41.7. The list is not intended to be all inclusive and consideration must be given to all resources.

(e) **Home/real property.** Home property is excluded from resources regardless of value. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as outlined in OAC 317:35-5-41(e)(6).

Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.

(1) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. The OHCA has not set a definite time limit to the member's absence from the home. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the reserve. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised in writing that the 90 day period begins with the determination that the property be considered in relation to the reserve. The 90 day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90 day period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.

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

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

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

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

(6) Absences from home for up to 90 days for trips or visits of six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home.

Emergency Adoptions

Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence. Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The Acknowledgment of Temporary Absence/Home Property Policy form is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the member, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

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

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

- (i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and
- (ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

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

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

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

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

a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

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

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

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

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

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

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

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

value of the property and the age of the life estate owner.

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

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

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

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

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

(B) **Non-trade or non-business property.** Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed \$6000, and the net return equals at least 6% of the equity annually. An equity value in excess of \$6000 is a countable resource. If the equity exceeds \$6000 and 6% return is received on the total equity, only the amount in excess of \$6000 is a countable resource. An annual return of less than 6% is acceptable if it is beyond the individual's control, and there is a reasonable expectation of a future 6% return. Liquid resources cannot be excluded as income producing property or meeting the \$6000/6% rule (mortgages,

including contract for deed, and notes which are income producing are considered as liquid resources). The \$6000/6% rule applies to all resources in total, and not separately. Examples of non-business income producing property are rental property, timber rights, mineral rights, etc.

(d) **Personal property.**

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

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

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

(B) Accounts which are owned jointly by the member and a person not receiving SoonerCare are considered available to the member in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the member is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one half of the account considered available to each.

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

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

Emergency Adoptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner).

(D) In instances where Management of Recipient's Funds form is on file in the nursing facility, the form serves as a power of attorney for the administrator to

purchase and/or elect to make irrevocable the burial funds for the member.

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

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

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

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

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

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

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

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

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

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

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

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

(v) **Grantor—(trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

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

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

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

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

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

Emergency Adoptions

- (xi) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.
- (xii) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.
- (C) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:
- (i) Trust document;
 - (ii) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and
 - (iii) Documentation reflecting prior disbursements (date, amount, purpose).
- (D) **Trust accounts established on or before August 10, 1993.** The rules found in (i)–(iii) of this subparagraph apply to trust accounts established on or before August 10, 1993.
- (i) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (I)–(III) of this unit, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:
- (I) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;
 - (II) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and
 - (III) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show

to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

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

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

(II) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of

the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

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

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

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

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

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

trust and if the trust was established other than by will and by any of the following individuals:

- (I) the individual;
- (II) the individual's spouse;
- (III) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- (IV) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

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

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

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

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

Emergency Adoptions

for purposes of the asset transfer rules and are subject to the 60 months look back period.

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

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

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

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

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

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

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

(VI) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

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

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

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

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

(I) The individual is in need of long term care and has countable income above the categorically needy standard for long term care (OKDHS Appendix C 1) but less than \$3000 per month.

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

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

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

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

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

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

(VIII) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements

cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

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

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

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

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

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

(II) The trust must be made irrevocable;

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

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

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

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

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

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

(G) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or

restricted lands shall not be considered a resource in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

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

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

(A) **Annuities.**

(i) ~~Annuities purchased prior to February 1, 2005. An annuity gives the right to receive fixed, periodic payments either for life or a term of years. The annuity instrument itself must be examined to determine the provisions and requirements of the annuity. For example, it is determined whether the individual can access the principal of the annuity; e.g., can it be cashed in. If so, the annuity is treated as a revocable trust (OAC 317:35-5-41(d)(9)(E)(iii)(I). If the individual cannot access the principal, the annuity is treated as an irrevocable trust. In this instance, it must also be determined what part of the annuity can, under any circumstances, be paid to, or for the benefit of the individual. When making such a determination, the date of application is used or, if later, the date of institutionalization (for an institutionalized individual) or the date of creation of the annuity (for a non-institutionalized individual). Also, these dates are used in determining whether the transfer of asset provisions apply to a particular annuity. If the annuity provides for payments to be made to the individual, those payments would be considered income to the individual. Any portion of the principal of the annuity that could be paid to or on behalf of the individual would be treated as a resource to the individual and portions of the annuity that cannot be paid to or for the benefit of the individual are treated as transfers of assets. Annuities may also be a transfer of assets for less than fair market value. The worker determines, in accordance with the OKDHS life expectancy tables, whether the member will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the member during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed.~~

(ii) ~~Annuities purchased after January 31, 2005.~~

(I) ~~An annuity is presumed to be an available resource to the individual who will receive the payments because the annuity can be sold.~~

Emergency Adoptions

The value of the annuity is the total of all remaining payments, discounted by the Applicable Federal Rate set by the IRS for the valuation of annuities for the month of application or review.

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

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

(i) **Countability of asset.** In each case, the document governing the retirement instrument must be examined to determine the availability of the retirement benefit at the time of application. Retirement benefits are considered countable resources if the benefits are available to the applicant and/or spouse. Availability means that the applicant and/or spouse has an option to receive retirement benefits or is actually receiving benefits. For example, a retirement instrument may make a fund available at the time of termination of employment, at age 65, or at some other time. A retirement fund is not a countable resource if the applicant is currently working and must terminate employment in order to receive benefits. An individual may have the choice of withdrawing the monies from the retirement fund in a single payment or periodic payments (i.e., monthly, quarterly, etc.). If the individual elects to receive a periodic payment, the payments are considered as income as provided in OAC 317:35-5-42(c)(3). If the monies are received as a lump sum, the rules at OAC 317:35-5-42(c)(3)(C)(i) apply.

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

(iii) **Timing of valuation.** Retirement funds are a countable resource in the month that the funds are available to the applicant. For purposes of this subsection, the month that the funds are available means the month following the month of application for the funds. For example, the retirement instrument makes retirement funds available at age 65. The applicant turns 65 on January 1st. The applicant makes a request for the funds on February 1st and the monies are received

on June 1st. The retirement fund would be considered as a countable resource in the month of March. The resource would not be counted in the month in which it is later received.

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

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

- (i) for medical services 4 times a year to obtain either medical treatment or prescription drugs; or
- (ii) for employment purposes; or
- (iii) especially equipped for operation by or transportation of a handicapped person.

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

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

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

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

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

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

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

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

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

~~(D) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:~~

~~(i) an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, OKDHS Form ADM 103, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or Form ADM 103 are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.~~

~~(ii) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.~~

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

~~(E) Indian payments or items purchased from Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;~~

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

~~(G) Benefits from State and Community Programs on Aging (Title III) are disregarded. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;~~

~~(H) Payments for supportive services or reimbursement of out-of-pocket expenses made to individual~~

~~volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Services Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);~~

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

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

~~(K) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;~~

~~(L) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;~~

~~(M) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);~~

~~(N) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;~~

~~(O) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;~~

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

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

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

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

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

~~(U) Dedicated bank accounts established by representative payees to receive and maintain retroactive~~

Emergency Adoptions

SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released; and

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

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

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

(2) **Capital resources acquired while receiving assistance.** If the member acquires resources which increase his/her available reserve above the maximum, he/she is ineligible for assistance unless there are specific plans for using the resources in compliance with rules on "resources disposed of while receiving assistance". The term "using the resource" is construed to mean that the resource has been encumbered or actually transferred. If the facts show a reasonable delay in executing the plan to use the required resource or if the resource is in a form which is not available for immediate use (such as real estate, mineral rights, or one of many other forms), and if efforts are in progress to make the resource available, the member is given a reasonable amount of time to make this available. The member is notified in writing that a period of time not to exceed 90 days will be given to make the resources available.

(A) Any extension beyond the initial 90 day period is justified only after interviewing the member, determining that a good faith effort is still being made and

that failure to make the resource available is due to circumstances beyond the control of the member.

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

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

(1) For each minor blind or disabled child up to the age of 18 living with parent(s) whose needs are not included in a TANF grant, or receiving SSI and/or SSP, the resource limit is the same as the individual limit as shown on OKDHS Appendix C-1. If the parent's resources exceed the maximum amount, the excess is deemed available to the child (resources of an ineligible child are not deemed to an eligible child). If there is more than one eligible child, the amount is prorated.

(2) If the minor blind or disabled child:

(A) is residing in a nursing facility, or a medical facility if the confinement lasts or is expected to last for 30 days, the parent(s)' resources are not deemed to the child; or

(B) under age 19 is eligible for TEFRA, the parent(s)' resources are not deemed to the child.

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

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

317:35-5-41.1. Home/real property

(a) Home property is excluded from resources regardless of value unless the individual is applying for long-term care services. [See 317:35-5-41.8(a) (relating to eligibility for long-term care services)]

(b) For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as

outlined in OAC 317:35-5-41.8(a)(2). Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with specialized individuals knowledgeable in the type and location of property being considered.

(1) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. When it is determined that the member does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the resource. The member is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the member is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised in writing that the 90-day period begins with the determination that the property be considered in relation to the resource. The 90-day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the member, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the member. A written notification is also provided to the member at any time an extension is allowed. Detailed documentation in the case record is required.

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

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

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

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

(6) Absences from home for up to 90 days for trips or visits or six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may

indicate the home no longer serves as the principal place of residence.

(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with the home property are considered as a resource. Since evaluation and scalability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property. Refer to (11)(B) of this subsection for treatment of mineral rights as non-trade or non-business property.

(8) The market value of real estate other than home property owned by the member or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the member of a merchantable title to be determined when the resource approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral or written information which the applicant has on hand and counsel with persons who have specialized knowledge about this kind of resource. Refer to (11) of this subsection for exclusion of real estate that produces income.

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

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

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

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

(C) In the event the member does not accept as valid the value of the life estate as established

Emergency Adoptions

through this method, the member must secure written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the member will jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current market values and who is acceptable to both the member and the worker.

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

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

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

317:35-5-41.2. Miscellaneous Personal property

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

mechanized equipment for gardening, livestock grown for home consumption, etc.

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

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

(2) **Accounts which are owned jointly** by the member and a person not receiving SoonerCare are considered available to the member in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the member is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.

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

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

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

(3) **The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon)** usually can be verified by inspection of the insurance policies and documents in the member's possession or by use of the OKDHS Form 08MP061E, Request to Insurance Company.

(4) **Dividends which accrue and which remain with the insurance company increase the amount of resource.** Dividends which are paid to the member are considered as income.

(5) **If an individual has a life insurance policy which allows death benefits to be received while living, and the individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds.** However, if the individual does file

for and receive the benefits, the payment will be considered as income in the month it is received and countable as a resource in the following months to the extent it is available. The payment of such benefits is not considered a conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

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

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

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

(2) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (1) of this subsection.

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

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

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

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

(1) If the irrevocable election was made prior to July 1, 1986, and the member received assistance on July 1, 1986, the full amount of the irrevocable contract is not considered a countable resource. This exclusion applies only if the member does not add to the amount of the contract.

Interest accrued on the contract is not considered as added by the member. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (2) of this subsection.

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

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

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

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

(3) For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner).

(4) In instances where the OKDHS Form 08MA084E, Management of Recipient's Funds, is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the member.

(g) **Medical insurance.** If a member is covered by insurance other than SoonerCare, then SoonerCare is the payer of last resort and should not be bill until all other payers have paid. If payment is made directly to the member, the member must reimburse OHCA up to the amount paid by SoonerCare. Any amount remaining after payment to OHCA is considered as an available resource.

317:35-5-41.3. Automobiles, pickups, and trucks

Automobiles, pickups, and trucks are considered in the eligibility determination for SoonerCare benefits.

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

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

(B) for employment purposes; or

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

(2) **Other automobiles.** The equity in other automobiles, pickups, and trucks is considered as a countable resource. The current market value, less encumbrances on the vehicle, is the equity. Only encumbrances that can be verified are considered in computing equity.

Emergency Adoptions

(A) The market value of each year's make and model is established on the basis of the "Avg. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports".

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

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

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

317:35-5-41.4. Stocks and bonds

(a) The member's equity in stocks and bonds (including U.S. Savings Bonds series A thru EE) is considered in relation to the maximum resource limit. The current market value less encumbrances is the equity. In general, determination of current market value can be obtained from daily newspaper quotations, brokerage houses, banks, etc.

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

317:35-5-41.5. Purchase of promissory notes, loans, or mortgages

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

(b) Promissory Notes, loans, and mortgages (including contracts for deed) which are income producing are liquid countable resources.

(c) For an individual who has purchased a promissory note, loan, or mortgage on or after February 8, 2006, and is applying for long-term care services, see OAC 317:35-5-41.8(b).

317:35-5-41.6. Trust accounts

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

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the OKDHS State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

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

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

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

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

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

(E) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

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

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

month of receipt and the availability of the principal in subsequent months.

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

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

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

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

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

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

(A) Trust document;

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

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

(4) Trust accounts established on or before August 10, 1993. The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

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

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

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

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

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

(i) Similar legal device. MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement

Emergency Adoptions

constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

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

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

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

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

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

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

(i) the individual;

(ii) the individual's spouse;

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

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

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

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

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Home property in a revocable trust under the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41.8(a)(2). Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

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

disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

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

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

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

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

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

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

(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

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

(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust.

Workers may give the sample form to the member or his/her representative to use or for their attorney's use.

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

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

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1) but less than \$3000 per month.

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

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

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

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

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

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

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

Emergency Adoptions

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

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

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

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

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

(ii) The trust must be made irrevocable;

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

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

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

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

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

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

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

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

317:35-5-41.7. Retirement funds

The rules regarding the countable value, if any, of retirement funds are found in (1) - (2) of this subsection.

(1) **Annuities.**

(A) Annuities purchased prior to February 1, 2005. An annuity gives the right to receive fixed, periodic payments either for life or a term of years. The annuity instrument itself must be examined to determine the provisions and requirements of the annuity. For example, it is determined whether the individual can access the principal of the annuity; e.g., can it be cashed in. If so, the annuity is treated as a revocable trust (OAC 317:35-5-41.6(a)(5)(C)(i)). If the individual cannot access the principal, the annuity is treated as an irrevocable trust. In this instance, it must also be determined what part of the annuity can, under any circumstances, be paid to, or for the benefit of the individual. When making such a determination, the date of application is used or, if later, the date of institutionalization (for an institutionalized individual) or the date of creation of the annuity (for a non-institutionalized individual). Also, these dates are used in determining whether the transfer of asset provisions apply to a particular annuity. If the annuity provides for payments to be made to the individual, those payments would be considered income to the individual. Any portion of the principal of the annuity that could be paid to or on behalf of the individual would be treated as a resource to the individual and portions of the annuity that cannot be paid to or for the benefit of the individual are treated as transfers of assets. Annuities may also be a transfer of assets for less than fair market value. The worker determines, in accordance with the OKDHS life expectancy tables, whether the member will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the member during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed.

(B) Annuities purchased after January 31, 2005.

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

(ii) The applicant or member may rebut the presumption that the annuity can be sold by showing compelling evidence to the contrary, in which

case the annuity is not considered available. The applicant or member may also rebut the presumed annuity value by showing compelling evidence that the actual value of the annuity is less than the presumed value.

(C) For an individual who has purchased an annuity on or after February 8, 2006, and is applying for long-term care services, see OAC 317:35-5-41.8(c).

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

(A) **Countability of asset.** In each case, the document governing the retirement instrument must be examined to determine the availability of the retirement benefit at the time of application. Retirement benefits are considered countable resources if the benefits are available to the applicant and/or spouse. Availability means that the applicant and/or spouse has an option to receive retirement benefits or is actually receiving benefits. For example, a retirement instrument may make a fund available at the time of termination of employment, at age 65, or at some other time. A retirement fund is not a countable resource if the applicant is currently working and must terminate employment in order to receive benefits. An individual may have the choice of withdrawing the monies from the retirement fund in a single payment or periodic payments (i.e., monthly, quarterly, etc.). If the individual elects to receive a periodic payment, the payments are considered as income as provided in OAC 317:35-5-42(c)(3). If the monies are received as a lump sum, the rules at OAC 317:35-5-42(c)(3)(C)(i) apply.

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

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

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property.** In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds \$500,000.

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include services detailed in (A) through (B) of this paragraph.

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds \$500,000 is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding \$500,000 would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life. If the undue hardship exists because the applicant was exploited, legal action must be pursued before a hardship waiver will be granted. Pursuing legal action means an APS referral has been made to the district attorney's office or a lawsuit has been filed and is being pursued against the perpetrator.

(3) Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the member, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member

Emergency Adoptions

cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

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

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

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

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

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

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

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

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

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

(b) Promissory notes, loans, or mortgages. The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage

meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) Annuities. Treatment of annuities purchased on or after February 8, 2006.

(1) The entire amount used to purchase an annuity on or after February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in (A) through (C) of this paragraph.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(B) The annuity is purchased with proceeds from:
(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986; or

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(2) In addition, the entire amount used to purchase an annuity on or after February 8, 2006, is treated as a transfer of assets unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:

(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

(d) Life Estates. This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

317:35-5-41.9. Resource disregards

In determining need, the following are not considered as resources:

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

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

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

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(A) an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

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

(5) Indian payments or items purchased from Indian payments (including judgement funds or funds held in

trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

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

(7) Benefits from State and Community Programs on Aging (Title III) are disregarded. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

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

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

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

(11) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(12) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(13) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(14) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(15) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

Emergency Adoptions

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

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

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

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

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

(21) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released; and

(22) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC 317:35-5-41.6 regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment.

317:35-5-41.10. Changes in capital resources

(a) **Capital resources of an applicant or member currently receiving assistance.** If the resource(s) of an applicant is in a form which is not available for immediate use, such as real estate, mineral rights, or one of many other forms, and the applicant is trying to make the resource available, the applicant may be certified and given a reasonable amount of time to make this available. If a member who is currently receiving medical assistance acquires resources which increase his/her available resources at an amount above the maximum resource standard, he/she is given a reasonable amount of time to make the resources available. A reasonable amount of time would normally not exceed 90 days. The member is notified in writing that a period of time not to exceed 90 days will be given to make the resource available. Any extension beyond the initial 90 day period is justified only after interviewing the member, determining that a good faith effort is still being made and that

failure to make the resource available is due to circumstances beyond the control of the member.

(b) **Money borrowed on member's resources.** Money borrowed on any of the member's resources, except the home, merely changes his/her resource from one form to another. Money borrowed on the home is evaluated in relation to the maximum resource standard.

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

317:35-5-41.11. Maximum resources

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

(1) For each minor blind or disabled child up to the age of 18 living with parent(s) whose needs are not included in a TANF grant, or receiving SSI and/or SSP, the resource limit is the same as the individual limit as shown on OKDHS Appendix C-1. If the parent's resources exceed the maximum amount, the excess is deemed available to the child (resources of an ineligible child are not deemed to an eligible child). If there is more than one eligible child, the amount is prorated.

(2) If the minor blind or disabled child:

(A) is residing in a nursing facility, or a medical facility if the confinement lasts or is expected to last for 30 days, the parent(s)' resources are not deemed to the child; or

(B) under age 19 is eligible for TEFRA, the parent's(s)' resources are not deemed to the child.

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

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

317:35-5-45. Determination of income and resources for categorical relationship to AFDC

Income is determined in accordance with OAC 317:35-10 for individuals categorically related to AFDC. Unless questionable, the income of categorically needy individuals who are categorically related to AFDC does not require verification.

Individuals categorically related to AFDC are excluded from the AFDC resource test. Certain AFDC rules are specific to money payment cases and are not applicable when only Medicaid SoonerCare services are requested. Exceptions to the AFDC rules are:

- (1) the deeming of the parent(s)' income to the minor parent;
- (2) the deeming of the sponsor's income to the sponsored alien;
- (3) the deeming of stepparent income to the stepchildren. The income of the stepparent who is not included for Medicaid SoonerCare in a family case is not deemed according to the stepparent liability. Only the amount of the stepparent's contribution to the individual is considered as income. The amount of contribution is determined according to OAC 317:35-10-26(a)(8), Person acting in the role of a spouse;
- (4) the AFDC lump sum income rule. For purposes of Medicaid SoonerCare eligibility, a period of ineligibility is not computed;
- (5) mandatory inclusion of minor blood-related siblings or minor dependent children. For Medicaid SoonerCare purposes, the family has the option to exclude minor blood-related siblings and/or minor dependent children;
- (6) the exemption of real property as a resource for up to six months based on the ~~client-member~~ signing OKDHS Form ~~C-6~~ 08TA016E, Agreement to Repay;
- (7) the disregard of one half of the earned income;
- (8) dependent care expense. For Medicaid SoonerCare only, dependent care expenses may be deducted for an in-home provider who, though not approved, would have qualified had the qualification process been followed;
- (9) AFDC trust rule. The availability of trusts for all Medicaid SoonerCare only cases is determined according to OAC 317:35-5-41(d)(9) OAC 317:35-5-41.6;
- (10) AFDC Striker rules. Striker status has no bearing on Medicaid SoonerCare eligibility;
- (11) ET&E Sanction rule. The ET&E status has no bearing on Medicaid SoonerCare eligibility. However, a new Medicaid SoonerCare application is required.

317:35-5-46. Determination of income and resources for categorical relationship to pregnancy-related services

Countable income for an individual categorically related to pregnancy-related services is determined the same as for an individual categorically related to AFDC. (See OAC 317:35-5-45). Eligibility is based on the income received in the first month of certification with changes in income not considered after certification. Countable resources are determined using the methodology for SSI eligibility (OAC 317:35-5-41 through 317:35-5-41.11). A change in the individual's resources must be reported, as resource eligibility continues through the certification period.

317:35-5-47. Determination of income and resources for categorical relationship to Disability for TB infected individuals

Countable income and resources for an individual categorically related because of a diagnosis of TB are determined in accordance with rules for individuals determined aged, blind, or disabled. (See OAC 317:35-5-41 through 317:35-5-41.11 and 317:35-5-42.)

317:35-5-49. Determination of income and resources for categorical relationship to TEFRA

Countable income and resources for a child categorically related to disability for TEFRA are determined in accordance with rules for individuals determined aged, blind, or disabled (see OAC 317:35-5-41 through 317:35-5-41.11, 317:35-5-42, and 317:35-7-36). Income and resources may not exceed the maximum standards as shown on OKDHS Appendix C-1, Schedules VIII. B. and D.

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 2. MEDICAID RECOVERY PROGRAM

317:35-9-15. Medicaid recovery

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the state to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded or other medical institution creates a debt to the Authority subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this Part. Recovery for payments made under Title XIX for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC ~~317:35-5-41(c)(6)(H)~~ 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include:

- (1) nursing facility services,
- (2) home and community based services,
- (3) related hospital services,
- (4) prescription drug services,
- (5) physician services, and
- (6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice

Emergency Adoptions

and opportunity for a hearing (OKDHS will conduct hearings), against the real property of a member who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances.

(1) **Exceptions to filing a lien.** A lien may not be filed on the home property if the member's family includes:

- (A) a surviving spouse residing in the home, or
- (B) a child or children age 20 or less lawfully residing in the home, or
- (C) a disabled child or children of any age lawfully residing in the home, or
- (D) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(2) **Reasonable expectation to return home.** A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care ~~shall constitute~~ constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least 90 days. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program form. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

(3) **Undue hardship waiver.** When enforcing a lien or a recovery from an estate [see (c) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when

application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, when the individual or his/her family is merely inconvenienced or when their life style is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted. If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.

(4) **Filing the lien.** After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of an intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative by certified mail. The lien must contain the following information:

- (A) the name and mailing address of the member, spouse, legal guardian, authorized representative, or individual acting on behalf of the member,
- (B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for Title XIX on the member's behalf,
- (C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for the mentally retarded or other medical institution,
- (D) the legal description of the real property against which the lien will be recorded, and
- (E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien.** The lien filed by OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

- (A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;
- (B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;
- (C) when there is no adult child of the member, natural or adopted, who is blind or disabled, as defined in OAC 317:35-1-2, residing in the home;
- (D) when no brother or sister of the member is lawfully residing in the home, who has resided there for

at least one year immediately before the date of the member's admission to the nursing facility, and has resided there on a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the ~~DHS~~ OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien.** The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is attached, for a period of more than 90 days without being re-admitted to a facility providing nursing care, even though there may have been no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources.** Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery from estates.**

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.

(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.

(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.

(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.

PART 7. DETERMINATION OF FINANCIAL ELIGIBILITY

317:35-9-65. General financial eligibility requirements for ICF/MR, HCBW/MR, and individuals age 65 or older in mental health hospitals

Financial eligibility for these types of long-term medical care is determined using the rules on income and resources according to the category to which the individual is related. (See OAC 317:35-10 for individuals categorically related to AFDC, and OAC 317:35-7-36 for those categorically related to ABD.)

(1) Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for long-term medical care.

(2) To be eligible for long-term care in an ICF/MR (private and public), HCBW/MR services and for persons 65 years or older in mental health hospitals, the individual must be determined categorically needy according to the standards appropriate to the categorical relationship.

(3) If the individual's gross income exceeds the categorically needy standard as shown on ~~DHS~~ OKDHS Appendix C-1, Schedule VIII. B. 1., refer to OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B) for rules on establishing a Medicaid Income Pension Trust.

(4) When eligibility for long-term care has been determined, the vendor payment amount, if applicable, is determined based on type of care, categorical relationship, community spouse, etc. Individuals determined eligible for HCBW/MR services will not have a vendor payment.

(5) The spenddown is applied to the vendor payment on the first claim(s) received on behalf of the individual.

(6) For an individual eligible for long-term care in an ICF/MR (private and public) or for an individual 65 years or older in a mental health hospital, the individual's share of the vendor payment is not prorated over the month. As ~~Medicaid~~ SoonerCare is the payer of last resort, the full amount of the ~~recipient's~~ member's share of the vendor payment must first be applied to the facility's charges before ~~Medicaid~~ SoonerCare reimbursement begins.

Emergency Adoptions

317:35-9-68. Determining financial eligibility for care in an ICF/MR (public and private), for HCBW/MR services, and for persons age 65 or older in mental health hospitals

(a) **Determining financial eligibility for care in an ICF/MR.** Financial eligibility and spenddown for individuals in an ICF/MR is determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility for ICF/MR care.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~DHS OKDHS~~ Appendix C-1, Schedule VIII. B. 1., to be eligible for ICF/MR services. If the individual's gross income exceeds this standard, refer to ~~Medicaid~~ SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-42(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ICF/MR services. His/her countable cannot exceed the maximum resource standard listed in ~~DHS OKDHS~~ Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/MR services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/MR, the individual's share of the vendor payment is not prorated over the month. As ~~Medicaid~~ SoonerCare is the payer of last resort, the full amount of the ~~recipient's member's~~ share of the vendor payment must first be applied to the facility's charges before ~~Medicaid~~ SoonerCare reimbursement begins.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse ~~is~~ is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~DHS OKDHS~~ Appendix C-1, Schedule VIII. B. 1., to be eligible for ICF/MR care. If the individual's gross income exceeds this standard, refer to ~~Medicaid~~ SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or ICF/MR, receives ADvantage or HCBW/MR services, or is 65 or older and in a mental health hospital

to be eligible for ICF/MR services, his/her countable resources cannot exceed the maximum ~~reserve~~ resource standard for an individual listed in DHS OKDHS Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** When eligibility for ICF/MR services has been determined, the vendor payment is computed. For an individual eligible for long-term care in an ICF/MR, the individual's share of the vendor payment is not prorated over the month. As ~~Medicaid~~ Medicaid SoonerCare is the payer of last resort, the full amount of the ~~recipient's~~ member's share of the vendor payment must first be applied to the facility's charges before ~~Medicaid~~ Medicaid SoonerCare reimbursement begins.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

- (i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.
- (ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/MR services.** When an individual and spouse are separated due to the individual entering an ICF/MR, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the ICF/MR, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in this subparagraph apply:

- (i) If payment of income is made solely to one or the other, the income is considered available only to that individual.
- (ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on DHS OKDHS Appendix C-1, Schedule VIII. B. 1., refer to ~~Medicaid~~ Medicaid SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC 317:35-5-41(d)(9)(F)(ii) 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the ICF/MR. DHS OKDHS Form MA-11 08MA011E, Assessment of Assets, is used for the assessment prior to application for ~~Medicaid~~ Medicaid SoonerCare. The amount determined as the spousal share is used for all subsequent applications for ~~Medicaid~~ Medicaid SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for ~~Medicaid~~ Medicaid SoonerCare is made at the same time the individual enters the ICF/MR, DHS OKDHS Form MA-12 08MA012E, Title XIX Worksheet, is used in lieu of ~~DHS OKDHS Form MA-11 08MA011E.~~

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the ICF/MR.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on ~~DHS OKDHS Appendix C-1, Section XI.~~

(iii) The minimum resource standard for the community spouse is found on DHS OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for ~~Medicaid~~

Emergency Adoptions

SoonerCare. At the first redetermination of eligibility, the ~~social~~ worker must document that the resources have been transferred. After the first year of Medicaid SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for Medicaid SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the ICF/MR.

(vii) The resources determined for the individual in the ICF/MR cannot exceed the maximum ~~reserve~~ resource standard for an individual as shown in ~~DHS~~ OKDHS Appendix C-1, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into an ICF/MR, that amount is used when determining resource eligibility for a subsequent Medicaid SoonerCare application for ICF/MR.

(ix) Once a determination of eligibility for Medicaid SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance ~~shall be~~ is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available to the community spouse;
- (III) determination of the spousal share of resource;
- (IV) the attribution of resources (amount deemed); or
- (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an ICF/MR and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is interrupted by a hospital stay or the individual is deceased before the 30-day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an ICF/MR on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse does not affect the eligibility of the spouse in the ICF/MR.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in an ICF/MR, the individual's share of the vendor payment is not prorated over the month. As Medicaid SoonerCare is the payer of last resort, the full amount of the ~~recipient's~~ member's share of the vendor payment must first be applied to the facility's charges before Medicaid SoonerCare reimbursement begins.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one month's vendor payment, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

(b) **Determining financial eligibility for HCBW/MR.** For individuals determined eligible for HCBW/MR services, there is no vendor payment. Financial eligibility for HCBW/MR services for a single individual is determined the same as for ICF/MR services as outlined in paragraph (a)(1) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/MR services for an individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital is determined the same as for ICF/MR services as outlined in paragraph (a)(2) of this Section with the exception of the vendor payment. Financial eligibility for HCBW/MR services for an individual with a spouse in the home who does not receive ADvantage or HCBW/MR services is determined the same as for an individual with a community spouse according to paragraph (a)(3) of this Section. If the individual is a minor child who can be determined categorically needy and SSP eligible by considering the parent(s)' income and resources in the deeming process, the case is handled in the usual manner. If the child is not eligible for SSP only because of the deeming of parent(s)' income/resources, financial eligibility for HCBW/MR services is determined using only the

child's income/resources and exempting the parent(s)' income and resources from the deeming process.

(c) **Determining financial eligibility for persons age 65 years or older in mental health hospitals.** The eligibility determination for an individual age 65 or older in a mental health hospital as categorically needy is the same as for any other person who is institutionalized. (Refer to subsection (a) in this Section.) The same procedure for determining excess income to be applied to the vendor payment as described in this Section is applicable.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-9. General financial eligibility requirements for the ADvantage program

Financial eligibility for ADvantage services is determined using the rules on income and resources according to the category to which the individual is related. (See OAC 317:35-7-36 for categorically related to ABD.) Only individuals who are categorically related to ABD may be served through the ADvantage waiver.

- (1) Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for the ADvantage program.
- (2) To be eligible for long-term care in the ADvantage program, the individual must be determined categorically needy according to the ~~DHS~~ OKDHS Appendix C-1, Schedule VIII. B. 1. If the individual's gross income exceeds this standard, see OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B).

317:35-17-11. Determining financial eligibility for ADvantage program services

Financial eligibility for individuals in ADvantage program services is determined according to whether or not a spouse remains in the home.

- (1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.
 - (A) **Income eligibility.** To determine the income of the individual, the rules in (i) through (iii) of this subparagraph apply.
 - (i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.
 - (ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.
 - (iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income

exceeds that standard, refer to ~~Medicaid—Soon~~ erCare rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

- (B) **Resource eligibility.** In order for an individual without a spouse to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum ~~reserve resource~~ standard for an individual listed in OKDHS Appendix C-1, Schedule VIII. D.
- (C) **Vendor payment.** For individuals in the ADvantage program there is not a spenddown calculation as the ~~client member~~ does not pay a vendor payment.
- (D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum ~~reserve resource~~ standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

- (2) **Individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital.** For an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during the receipt of ADvantage program services.

- (A) **Income eligibility.** Income is determined separately for an individual and his/her spouse if the spouse is in the ADvantage or HCBW/MR program, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital. The income of either spouse is not considered as available to the other during the receipt of ADvantage services. The rules in (i) - (v) of this subparagraph apply in this situation:
 - (i) If payment of income is made solely to one or the other, the income is considered available only to that individual.
 - (ii) If payment of income is made to both, one-half is considered for each individual.
 - (iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.
 - (iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

Emergency Adoptions

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to ~~Medicaid~~ SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who receives ADvantage or HCBW/MR services, or is institutionalized in a NF or ICF/MR, or is 65 or older and in a mental health hospital to be eligible for ADvantage services, his/her countable resources cannot exceed the maximum ~~reserve resource~~ standard for an individual listed in OKDHS Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** For individuals in the ADvantage program, there is no spenddown calculation as the ~~client member~~ does not pay a vendor payment.

(D) **Equity in capital resources.** If the equity in the individual's capital resources is in excess of the maximum ~~reserve resource~~ standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the ~~resources~~ resources came within the standard. If the excess capital resources can not reasonably be expected to come within standards in one month, the application is denied.

(3) **Individual with a spouse in the home who is not in the ADvantage or HCBW/MR program.** When only one individual of a couple in their own home is in the ADvantage or HCBW/MR program, income and resources are determined separately. However, the income and resources of the individual who is not in the ADvantage or HCBW/MR program (community spouse) must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in ADvantage program services, the income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the rules in (i) - (v) of this subparagraph apply.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if

payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual in the ADvantage program services cannot exceed the categorically needy standard in OKDHS Appendix C-1, Schedule VIII. B. 1., to be eligible for care. If the individual's gross income exceeds this standard, refer to ~~Medicaid~~ SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's application for the ADvantage program. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse receiving ADvantage program services. The amount determined as the spousal share is used for all subsequent applications for ~~Medicaid~~ SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for ~~Medicaid~~ SoonerCare is made at the same time the individual begins receiving ADvantage program services, OKDHS Form MA-12 08MA012E, Title XIX Worksheet, is used.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the month of application of the spouse into the ADvantage program services (regardless of payment source).

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on OKDHS Appendix C-1, Schedule XI.

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse, the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for ~~Medicaid~~ SoonerCare. At the first redetermination of

eligibility, the worker must document that the resources have been transferred. After the first year of Medicaid SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standard and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for Medicaid SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse receiving ADvantage program services.

(vii) The resources determined in (i) - (vi) of this subparagraph for the individual receiving ADvantage program services cannot exceed the maximum reserve resource standard for an individual as shown in OKDHS Appendix C-1, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into the ADvantage program service, that amount is used when determining resource eligibility for a subsequent Medicaid SoonerCare application for Long-Term Care for either spouse.

(ix) Once a determination of eligibility for Medicaid SoonerCare is made, either spouse is entitled to a fair hearing. A fair hearing regarding the determination of the community spouse's resource allowance ~~shall be~~ is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available to the community spouse;
- (III) determination of the spousal share of resource;
- (IV) the attribution of resources (amount deemed); or
- (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual receiving ADvantage program services is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met

even if a hospital stay interrupts it or the individual is deceased before the 30-day period ends.

(C) **Vendor payment.** There is not a spenddown calculation for individuals receiving ADvantage program services as the client member does not pay a vendor payment.

(D) **Excess resources.** If the equity in the individual's capital resources is in excess of the maximum reserve resource standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources cannot reasonably be expected to come within standards in one month, the application is denied.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-4. Medicaid recovery

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the state to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded or other medical institution creates a debt to the Authority subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this part. Recovery for payments made under Title XIX for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC ~~317:35-5-41(c)(6)(H)~~ 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include:

- (1) nursing facility services,
- (2) home and community based services,
- (3) related hospital services,
- (4) prescription drug services,
- (5) physician services, and
- (6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice and opportunity for a hearing, (OKDHS will conduct hearings) against the real property of a member who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances.

Emergency Adoptions

(1) **Exceptions to filing a lien.** A lien may not be filed on the home property if the member's family includes:

- (A) a surviving spouse residing in the home, or
- (B) a child or children age 20 or less lawfully residing in the home, or
- (C) a disabled child or children of any age lawfully residing in the home, or
- (D) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(2) **Reasonable expectation to return home.** A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care ~~shall constitute~~ constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least three months. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program form. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

(3) **Undue hardship waiver.** When enforcing a lien or a recovery from an estate [see (C) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, where the individual

or his/her family is merely inconvenienced or where their life style is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted. If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.

(4) **Filing the lien.** After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of the intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative by certified mail. The lien must contain the following information:

- (A) the name and mailing address of the member, member's spouse, legal guardian, authorized representative, or individual acting on behalf of the member,
- (B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for XIX on the member's behalf,
- (C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for the mentally retarded or other medical institution,
- (D) the legal description of the real property against which the lien will be recorded, and
- (E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien.** The lien filed by the OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

- (A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;
- (B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;
- (C) when there is no adult child of the member, natural or adopted, who is blind or disabled as defined in, OAC 317:35-1-2 residing in the home;
- (D) when no brother or sister of the member is lawfully residing in the home, who has resided there for at least one year immediately before the date of the member's admission to the nursing facility, and has

resided there on a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien.** The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is attached, for a period of more than 90 days without being re-admitted to a facility providing nursing care, even though there may have been no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources.** Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery From Estates from estates.**

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.

(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or

assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.

(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.

(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.

317:35-19-19. General financial eligibility requirements for NF and skilled nursing care

(a) **Financial eligibility for NF care.** Financial eligibility for NF care is determined using the rules on income and resources according to the category to which the individual is related. (See OAC 317:35-10 for individuals categorically related to AFDC, and OAC 317:35-7-36 for those categorically related to ABD.)

(1) Income, resources and expenses are evaluated on a monthly basis for all individuals requesting payment for NF care. Each individual requesting payment for NF care is allowed a personal needs allowance.

(2) To be eligible for long-term care in an NF, the individual must be determined categorically needy according to the standards appropriate to the categorical relationship.

(3) If the individual's gross income exceeds the categorically needy standard as shown on ~~DHS OKDHS Appendix C-1, Schedule VIII. B. 1., refer to OAC 317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B) for rules on establishing a Medicaid Income Pension Trust.

(4) When eligibility for long-term care has been determined, the spenddown amount is determined based on type of care, categorical relationship, community spouse, etc.

(5) The spenddown is applied to the vendor payment on the first NF claim(s) received on behalf of the individual.

(6) For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As ~~Medicaid~~ SoonerCare is the payer of last resort, the full amount of the ~~recipient's~~ member's share of the vendor payment must first be applied to the facility's charges before ~~Medicaid~~ SoonerCare reimbursement begins.

(b) **Financial eligibility for skilled nursing.** Skilled Nursing Care is covered as part of the Medicare Part A coverage. For ~~clients~~ members who are currently receiving this benefit through the QMB program, no further action is needed. For individuals who do not have an active ~~Medicaid~~ SoonerCare case, an application is processed to receive the Medicare crossover and deductible benefits. Income eligibility is based on the categorically needy standard in ~~DHS OKDHS Appendix C-1, Schedule VI., for the first 30 days. After the initial 30 days, income eligibility is based on the categorically needy standard in~~ DHS OKDHS Appendix C-1, Schedule VIII. B. 1.

(1) QMB eligible individuals in skilled nursing care are allowed the resource standard as shown on ~~DHS OKDHS Appendix C-1, Schedule VI,~~ but must meet the ~~Medicaid~~ SoonerCare resource standard as shown on ~~DHS OKDHS~~

Emergency Adoptions

Appendix C-1, Schedule VIII. D., for NF level of care. For individuals with no active case, use the resource standard shown on ~~DHS OKDHS~~ Appendix C-1, Schedule VIII. D.

(2) Rules concerning transfer of assets do not apply to skilled level of care.

317:35-19-21. Determining financial eligibility for care in NF

Financial eligibility and vendor payment calculations for individuals in an NF are determined according to whether or not a spouse remains in the home.

(1) **Individual without a spouse.** For an individual without a spouse, the following rules are used to determine financial eligibility.

(A) **Income eligibility.** To determine the income of the individual without a spouse, the rules in (i) - (iii) of this subparagraph apply.

(i) If payment of income is made to the individual and another person(s), the income is considered in proportion to the individual's interest.

(ii) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(iii) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~DHS OKDHS~~ Appendix C-1, Schedule VIII. B. 1., to be eligible for NF services. If the individual's gross income exceeds this standard, refer to ~~Medicaid SoonerCare~~ rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual without a spouse to be eligible for NF services, his/her countable resources cannot exceed the maximum resource standard listed in ~~DHS OKDHS~~ Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF care has been determined, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As ~~Medicaid SoonerCare~~ is the payer of last resort, the full amount of the ~~recipient's member's~~ share of the vendor payment must first be applied to the facility's charges before ~~Medicaid SoonerCare~~ reimbursement begins.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

(i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.

(ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the

remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(2) **Individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital.** For an individual with a spouse who is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital, resources are determined for each individual as the amount owned by each individual plus one-half of the jointly owned resources of the couple. Once this separation of assets is made, a resource of either spouse is not considered available to the other during institutionalization.

(A) **Income eligibility.** To determine income for an individual whose spouse is institutionalized in a NF or ICF/MR, or who receives ADvantage or HCBW/MR services, or is 65 or over and in a mental health hospital, income determination is made individually. The income of either spouse is not considered as available to the other during institutionalization. The rules in (i) - (v) of this subparagraph apply in this situation.

(i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) After determination of income, the gross income of the individual cannot exceed the categorically needy standard in ~~DHS OKDHS~~ Appendix C-1, Schedule VIII. B. 1., to be eligible for ADvantage services. If the individual's gross income exceeds this standard, refer to ~~Medicaid SoonerCare~~ rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** In order for an individual with a spouse who is institutionalized in a NF or

ICF/MR, receives ADvantage or HCBW/MR services, or is 65 or older and in a mental health hospital to be eligible for NF services, his/her countable resources cannot exceed the maximum ~~reserve~~ resource standard for an individual listed in DHS OKDHS Appendix C-1, Schedule VIII. D.

(C) **Vendor payment.** When eligibility for NF services has been determined, the spenddown calculation is used to compute the vendor payment. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As Medicaid SoonerCare is the payer of last resort, the full amount of the ~~recipient's~~ member's share of the vendor payment must first be applied to the facility's charges before Medicaid SoonerCare reimbursement begins.

(D) **First month.** For the first month of care, the following procedures apply when determining the vendor payment:

- (i) When an individual enters the facility on the first day of the month, all countable income is considered with the facility maintenance standard allowed.
- (ii) When an individual enters the facility after the first day of the month, all countable income is considered with the own home standard allowed in computation of the vendor payment. Only the remaining income actually available is used to compute the vendor payment.

(E) **Equity in capital resources.** If the equity in capital resources is in excess of the standards, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of one month's vendor payment, the application is denied.

(3) **Individual with a spouse remaining in the home who does not receive ADvantage or HCBW/MR services.** When an individual and spouse are separated due to the individual entering an NF, income and resources are determined separately. However, the income and resources of the community spouse must be included on the application form. At redetermination of eligibility, the community spouse's income must be included in the review process. During any month that the individual is in the NF, income of the community spouse is not considered available to that individual. The following rules are used to determine the income and resources of each:

(A) **Income eligibility.** To determine the income of both spouses, the following rules in this subparagraph apply:

- (i) If payment of income is made solely to one or the other, the income is considered available only to that individual.

(ii) If payment of income is made to both, one-half is considered for each individual.

(iii) If payment of income is made to either one or both and another person(s), the income is considered in proportion to either the spouse's interest (if payment is to that spouse) or one-half of the joint interest if no interest is specified.

(iv) If a legal instrument exists which specifies terms of payment, income is considered according to the terms of the instrument.

(v) If the individual's gross income exceeds the categorically needy standard as shown on DHS OKDHS Appendix C-1, Schedule VIII. B. 1., refer to Medicaid SoonerCare rules for establishing a Medicaid Income Pension Trust [OAC ~~317:35-5-41(d)(9)(F)(ii)~~ 317:35-5-41.6(a)(6)(B)].

(B) **Resource eligibility.** To determine resource eligibility, it is necessary to determine the amount of resources for both spouses for the month of the individual's entry into the nursing facility. Of the resources available to the couple (both individual and joint ownership) an amount will be protected for the community spouse which will not be considered available to the spouse in the NF. ~~DHS OKDHS form Form MA-11 08MA011E~~, Assessment of Assets, is used for the assessment prior to application for Medicaid SoonerCare. The amount determined as the spousal share is used for all subsequent applications for Medicaid SoonerCare, regardless of changes in the couple's resources. The protected spousal share cannot be changed for any reason. When application for Medicaid SoonerCare is made at the same time the individual enters the NF, ~~DHS OKDHS form Form MA-12 08MA012E~~, Title XIX Worksheet, is used in lieu of ~~DHS OKDHS form Form MA-11 08MA011E~~.

(i) The first step in the assessment process is to establish the total amount of resources for the couple during the first month of the entry of the spouse into the NF.

(ii) The community spouse's share is equal to one-half of the total resources of the couple not to exceed the maximum amount of resource value that can be protected for the community spouse, as shown on ~~DHS OKDHS Appendix C-1, Schedule XI.~~

(iii) The minimum resource standard for the community spouse, as established by the OHCA, is found on DHS OKDHS Appendix C-1, Schedule XI. When the community spouse's share is less than the minimum standard, an amount may be deemed from the other spouse's share to ensure the minimum resource standard for the community spouse. If the community spouse's share equals or exceeds the minimum resource standard, deeming cannot be done.

(iv) If deeming is necessary to meet the minimum resource standard for the community spouse,

the amount that is deemed must be legally transferred to the community spouse within one year of the effective date of certification for Medicaid SoonerCare. At the first redetermination of eligibility, the ~~social~~ worker must document that the resources have been transferred. After the first year of Medicaid SoonerCare eligibility, resources of the community spouse will not be available to the other spouse and resources cannot be deemed to the community spouse.

(v) After the month in which the institutionalized spouse and community spouse have met the resource standards and the institutionalized spouse is determined eligible for benefits, no resources of the community spouse, regardless of value, will be considered available to the institutionalized spouse. If the resources of the community spouse grow to exceed the original deemed amount, the State cannot require the community spouse to apply any of these excess resources toward the cost of the care of the institutionalized spouse.

(vi) When determining eligibility for Medicaid SoonerCare, the community spouse's share of resources is protected and the remainder considered available to the spouse in the NF.

(vii) The resources determined above for the individual in the NF cannot exceed the maximum ~~reserve resource standard~~ for an individual as shown in DHS OKDHS Appendix C-1, Schedule VIII. D.

(viii) Once the dollar value of the community spouse's share of resources is established for the month of the other spouse's entry into NF, that amount is used when determining resource eligibility for a subsequent Medicaid SoonerCare application for NF.

(ix) Once a determination of eligibility for Medicaid SoonerCare is made, either spouse is entitled to a fair hearing. Any such hearing regarding the determination of the community spouse's resource allowance ~~shall be~~ is held within 30 days of the date of the request for the hearing. Either spouse is entitled to a fair hearing if dissatisfied with a determination of:

- (I) the community spouse's monthly income allowance;
- (II) the amount of monthly income otherwise available to the community spouse;
- (III) determination of the spousal share of resource;
- (IV) the attribution of resources (amount deemed); or
- (V) the determination of the community spouse's resource allowance.

(x) The rules on determination of income and resources are applicable only when an individual has entered an NF and is likely to remain under care for 30 consecutive days. The 30-day requirement is considered to have been met even if it is

interrupted by a hospital stay or the individual is deceased before the 30-day period ends.

(xi) The rules on resources included in this Section apply only to those cases in which an individual begins a continuous period of care in an NF on or after September 30, 1989.

(xii) If the individual was admitted prior to September 30, 1989, there is not a protected amount for the community spouse. Resources are separated according to spousal ownership with one-half of jointly owned resources counted for each. In this instance, each spouse's resources are considered separately and the resources of the community spouse does not affect the eligibility of the spouse in the NF.

(C) **Vendor payment.** After the institutionalized spouse has been determined eligible for long-term care, the vendor payment is computed. For an individual eligible for long-term care in a NF, the individual's share of the vendor payment is not prorated over the month. As Medicaid SoonerCare is the payer of last resort, the full amount of the ~~recipient's~~ member's share of the vendor payment must first be applied to the facility's charges before Medicaid SoonerCare reimbursement begins.

(D) **Excess resources.** If the equity in capital resources is in excess of the standards but less than the amount of one month's vendor payment, certification is delayed up to 30 days providing plans are made for the applicant to utilize the excess resource. Certification is made at the point the excess resources have been exhausted, with the effective date of certification being shown as the date on which the resources came within the standard. If the excess capital resources, along with excess income to be considered against the vendor payment, are in excess of the vendor payment, the application is denied.

[OAR Docket #07-1413; filed 9-26-07]

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

[OAR Docket #07-1401]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 9. ICF/MR, HCBW/MR, and Individuals Age 65 or Older in Mental Health Hospitals

Part 5. Determination of Medical Eligibility for ICF/MR, HCBW/MR, and Individuals Age 65 and Older in Mental Health Hospitals
317:35-9-48.1. [NEW]

(Reference APA WF # 07-21)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 97-248 Tax Equity and Fiscal Responsibility Act of 1982

DATES:

Adoption:

June 14, 2007

Approved by Governor:

July 27, 2007

Effective:

Immediately upon Governor's approval or August 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that an imminent peril to the preservation of the public health, safety, and welfare exists which necessitates promulgation of emergency rules and requests emergency approval of rules to provide guidelines for determining Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care for children, used in determining medical eligibility for Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if they were residents of an institution. Without these guidelines, children may be left at home without needed services or inappropriately placed in an institution. The child would not be able to receive the treatment that best suits their condition.

ANALYSIS:

Rules are revised to establish guidelines for determining Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care for children as a condition of eligibility for the Tax Equity and Fiscal Responsibility Act (TEFRA). The TEFRA program provides needed services to children allowing them to remain in their own home. The institutional level of care determination allows the child's eligibility to be determined as though the child were institutionalized and therefore only his/her income and resources are considered in the eligibility determination. If guidelines are not established, children may be inappropriately institutionalized. Rule revisions are needed to add guidelines for ICF/MR level of care to provide a necessary component of children's applications to the TEFRA program.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-48.1. Determining ICF/MR institutional level of care for TEFRA children

In order to determine level of care for TEFRA children:

- (1) The child must be age 18 years or younger and expected to meet the following criteria for at least 30 days.

(A) Applicants under age three must:

- (i) have a diagnosis of a developmental disability; and
- (ii) have been evaluated by the SoonerStart Early Intervention Program and found to have severe dysfunctional deficiencies with findings of at least two standard deviations in at least two developmental areas.

(B) Applicants age three years and older must:

- (i) have a diagnosis of mental retardation or a developmental disability; and
- (ii) have received a psychological evaluation by a licensed psychologist or school psychologist certified by the Oklahoma Department of Education (ODE) within the last 12 months. The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/MR level of institutional care requires an IQ of 75 or less, and a full-scale functional assessment (Vineland or Battelle) indicating a functional age composite that does not exceed 50% of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight years.

- (2) Psychological evaluations required for children who are approved for TEFRA under ICF/MR level of care. Children under age six will be required to undergo a full psychological evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist or school psychologist certified by the ODE, at age three and again at age six to ascertain continued eligibility for TEFRA under the ICF/MR level of institutional care. The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third and sixth birthday.

[OAR Docket #07-1401; filed 9-26-07]

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE**

[OAR Docket #07-1408]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 9. O-EPIC PA Employee Eligibility

317:45-9-1. [AMENDED]

Subchapter 11. O-EPIC IP

Part 5. O-EPIC Individual Plan Member Eligibility

317:45-11-20. [AMENDED]

(Reference APA WF # 07-39)

Emergency Adoptions

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; House Bill 1225 of the 1st Session of the 51st Oklahoma Legislature

DATES:

Adoption:

August 15, 2007

Approved by Governor:

September 12, 2007

Effective:

Immediately upon Governor's approval or November 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to increase the current O-EPIC Employer Sponsored Insurance and O-EPIC Individual Plan maximum income standards from 185% to 200% of the federal poverty level. Revisions are needed to comply with House Bill 1225 of the 1st Session of the 51st Oklahoma Legislature to the extent that OHCA's currently approved SoonerCare 1115 demonstration waiver allows. Revisions will extend the option to purchase affordable health insurance to a larger group of low income, uninsured working adults.

ANALYSIS:

Agency rules are revised to increase the current O-EPIC Employer Sponsored Insurance (ESI) and O-EPIC Individual Plan (IP) maximum income standards to 200% of the federal poverty level. Currently, only working adults with countable household income at or below 185% of the federal poverty level can qualify for O-EPIC ESI or IP. Revisions are needed to comply with House Bill 1225 of the 1st Session of the 51st Oklahoma Legislature to the extent that OHCA's currently approved SoonerCare 1115 demonstration waiver allows. Revisions will extend the option to purchase affordable health insurance to a larger group of low income, uninsured working adults.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR NOVEMBER 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 9. O-EPIC PA EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

- Employee premium assistance applications are made with the TPA.
- The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the application is received by the TPA. The employee is notified in writing of the eligibility decision.
- All O-EPIC eligible employees described in this Section are enrolled in their Employer's QHP. Employees eligible for O-EPIC must:

- have a countable household income at or below ~~185%~~ 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member;
- be a US citizen or alien as described in OAC 317:35-5-25;
- be Oklahoma residents;
- provide his/her social security number;
- ~~be not be~~ currently enrolled in, or have an open application for, ~~Medicaid-SoonerCare/Medicare~~;
- be employed with a qualified employer at a business location in Oklahoma;
- be age 19 through age 64;
- be eligible for enrollment in the employer's Qualified Health Plan;
- be working for primary employer(s) who all meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
- select one of the Qualified Health Plans the employer is offering.

- An employee's spouse is eligible for O-EPIC if:
 - the employer's health plan includes coverage for spouses;
 - the employee is eligible for O-EPIC;
 - if employed, the spouse's primary employer(s) meets employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
 - the spouse is enrolled in the same health plan as the employee.
- If an employee or spouse is eligible for multiple O-EPIC Qualified Health Plans, each may receive a subsidy under only one health plan.

SUBCHAPTER 11. O-EPIC IP

PART 5. O-EPIC INDIVIDUAL PLAN MEMBER ELIGIBILITY

317:45-11-20. O-EPIC Individual Plan eligibility requirements

- Employees not eligible for participating in an employer's Qualified Health Plan (QHP), employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability may apply for the O-EPIC Individual Plan. Applicants cannot obtain O-EPIC IP coverage if they are eligible for O-EPIC PA.
- Applications may be found on the World Wide Web or may be requested by calling the O-EPIC helpline. Completed applications are submitted to the TPA.
- The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is

processed within 30 days from the date the complete application is received by the TPA. The applicant is notified in writing of the eligibility decision.

- (d) In order to be eligible for the IP, the applicant must:
 - (1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;
 - (2) be a US citizen or alien as described in OAC 317:35-5-25;
 - (3) be an Oklahoma resident;
 - (4) provide his/her social security number;
 - (5) be not be currently enrolled in, or have an open application for, Medicaid/SoonerCare/Medicare;
 - (6) be age 19 through 64; and
 - (7) make premium payments by the due date on the invoice.

(e) If employed and working for an approved O-EPIC employer who offers a QHP, the applicant must meet the requirements in subsection (d) of this Section and:

- (1) have household income at or below ~~185%~~ 200% of the Federal Poverty Level.
- (2) be ineligible for participation in their employer's QHP due to number of hours worked.
- (3) have received notification from O-EPIC indicating their employer has applied for O-EPIC and has been approved.

(f) If employed and working for an employer who doesn't offer a QHP, the applicant must meet the requirements in subsection (d) of this Section and:

- (1) have a countable household income at or below ~~185%~~ 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is \$240 per each full-time or part-time employed member; and
- (2) have received notification from O-EPIC indicating their employer has applied and has been approved with the attestation that they are not offering a QHP.

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

- (1) must have household income at or below ~~185%~~ 200% of the Federal Poverty Level;
- (2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms; and
- (3) verify current income by providing appropriate supporting documentation.

(h) If unemployed seeking work, the applicant must meet the requirements in subsection (d) of this Section and:

- (1) must have household income at or below ~~185%~~ 200% of the Federal Poverty Level; and
- (2) verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:
 - (A) OESC eligibility letter,
 - (B) OESC weekly unemployment payment statement, or
 - (C) bank statement showing state treasurer deposit.

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

- (1) must have household income at or below 200% of the Federal Poverty Level based on a family size of one; and
- (2) verify eligibility by providing a copy of their:
 - (A) ticket to work, or
 - (B) ticket to work offer letter.

[OAR Docket #07-1408; filed 9-26-07]

**TITLE 317. OKLAHOMA HEALTH CARE
AUTHORITY
CHAPTER 45. OKLAHOMA EMPLOYER
AND EMPLOYEE PARTNERSHIP FOR
INSURANCE COVERAGE**

[OAR Docket #07-1402]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 11. O-EPIC IP
Part 5. O-EPIC Individual Plan Member Eligibility
317:45-11-21.1. [NEW]
(Reference APA WF # 07-19)

AUTHORITY:

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 56 O.S. 2001, as amended; and 42 CFR §435.117

DATES:

Adoption:

June 14, 2007

Approved by Governor:

July 27, 2007

Effective:

Immediately upon Governor's approval or August 1, 2007, whichever is later

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Agency finds that an imminent peril to the preservation of the public health, safety or welfare exists which necessitates promulgation of emergency rules and requests emergency approval of rules to allow newborns of O-EPIC Individual Plan (IP) mothers to be deemed eligible for a year from birth for SoonerCare. Without health care in their first year of life, these children are at risk for long-term disabilities and adverse health conditions related to untreated illnesses.

ANALYSIS:

Rule revisions are needed to allow for 12 months of SoonerCare eligibility from birth for children born to O-EPIC Individual Plan (IP) members. Currently these children can receive SoonerCare benefits only after their mothers complete and return an application to OKDHS. This process often delays newborns and children from receiving needed medical benefits which puts children at risk for long-term disabilities and adverse health conditions related to untreated or preventable illnesses. Deeming newborns of O-EPIC IP members for SoonerCare at birth to 12 months of age will assure that these children receive needed medical benefits to treat and prevent illnesses. These rules mirror the same process for the deeming of low income families with children's newborn eligible for SoonerCare medical benefits for the first year of the newborn's life.

CONTACT PERSON:

Joanne Terlizzi at (405)522-7272

Emergency Adoptions

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D), AND EFFECTIVE UPON APPROVAL BY GOVERNOR OR AUGUST 1, 2007, WHICHEVER IS LATER:

SUBCHAPTER 11. O-EPIC IP

PART 5. O-EPIC INDIVIDUAL PLAN MEMBER ELIGIBILITY

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

(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Oklahoma Employer and Employee Partnership for Insurance Coverage Individual Plan (O-EPIC IP). (For purposes of this subparagraph, a newborn child is defined as any child under the age of one year). The newborn child is deemed eligible through the last day of the month the child attains the age of one year.

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

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

- (1) leaves the mother's home;
- (2) loses Oklahoma residence;
- (3) has medical needs included in another assistance case; or
- (4) expires.

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

[OAR Docket #07-1402; filed 9-26-07]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 25. LICENSURE OF PRODUCERS, ADJUSTERS, BAIL BONDSMEN, COMPANIES, PREPAID FUNERAL BENEFITS, AND VIATICAL AND LIFE SETTLEMENTS PROVIDERS AND BROKERS

[OAR Docket #07-1417]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:

Subchapter 3. Producers, Brokers and Limited Lines Producers [AMENDED]

365:25-3-1. Insurance producers continuing education [AMENDED]

365:25-3-1.1. Application for Resident Producer License [NEW]

365:25-3-1.2. Provisional Producer Licensees [NEW]

365:25-3-1.3 Approved Insurance Company Training Program [NEW]

365:25-3-14. Insurance adjusters continuing education [AMENDED]

Appendix T. Insurance Company Training Program Affidavit [NEW]

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307.1, 1435.7 (A)(3), 1435.19, 1435.29 (B)(3), B(4) and (H).

DATES:

Adoption:

September 11, 2007

Approved by Governor:

October 2, 2007

Effective:

November 1, 2007

Expiration:

Effective through July 14, 2008, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATION BY REFERENCE:

n/a

FINDING OF EMERGENCY:

A compelling public interest requires emergency rules to implement the recent changes to the Producer and Adjuster Licensing Acts. Effective July 1, 2007 and pursuant to House Bill 1960, the Commissioner may require applicants for resident producer licenses to either hold a provisional producer license or participate in an approved insurance company training program. Emergency rules are needed to implement the requirements for provisional producer licenses and insurance company training programs.

Effective July 1, 2007, continuing education requirements for producers and adjusters were amended. Prior to the statutory amendments, specific professional designation programs qualified for continuing education credit. A process of approval is now utilized to expand the number of professional designation programs available for continuing education credit. The statutory revision requires standardized criteria to review professional designation programs for approval. Rules are also necessary to define participation in approved professional designation programs.

Furthermore, certain continuing education programs offered by specified professional associations may receive presumptive approval. The promulgation of emergency rules is necessary to implement standards for presumptive approval.

ANALYSIS:

The rules state the requirements for obtaining a resident producer license. The rules clarify how many provisional licensees a sponsor may supervise and the length of time an applicant must hold a provisional producer license prior to applying for a producer license. The rules also define an approved insurance company training program and set forth the criteria for approval of such programs.

The rules further interpret and implement the recent amendments to producer and adjuster continuing education requirements. For example, the rules define an approved professional designation program and the requirements for receiving continuing education credit through this method of instruction. Finally, the rules include standardized criteria for presumptive approval of certain continuing education courses.

Comments regarding the proposed emergency rules were received from Reserve National Insurance Company and the American Council of Life Insurers ("ACLI"). Reserve National Insurance Company suggested that the emergency rules include rules for completing a pre-licensing course of study. The emergency rules do not address pre-licensing courses of study because the Commissioner is not requiring a pre-licensing course of study. The Commissioner is requiring either a provisional producer license or participation in an approved insurance company training program.

Proposed rule 365:25-3-1.3(c) was amended at ACLI's suggestion. The insurance company training program participation form is now required to be submitted with the producer application.

Proposed rule 365:25-3-1(g)(2)(D) was amended at ACLI's suggestion. The word "course" was included in paragraph (g)(2)(D) for similarity to paragraph (g)(1)(A).

Proposed rule 365:25-365:25-3-1(g)(2), (g)(3), and (g)(4) was not amended as suggested by ACLI. Professional designation programs are not approved as continuing education courses. The proposed rule allows continuing education credit for participating in an approved professional designation program. The proposed rule was amended to indicate that the program is being approved.

Professional designation programs recognized by the National Association of Insurance Commissioners ("NAIC") for waiver of pre-licensing education are approved as professional designation programs without submission requirements. Proposed rule 365:25-3-1-(g)(4) refers to the designations found in the NAIC's Uniform Licensing Standards for pre-licensing education training. The proposed rule does not apply to long term care designations. A list of approved designations will be published. The designations currently approved are CEBS, ChFC, CIC, CFP, CLU, FLMI, LUTCF, RHU, REBC, HIA, AAI, ARM, and CPCU.

Proposed Appendix T was amended to include role playing and customer interaction case studies for business training. Experienced agents new to a particular insurance company or new to a line of insurance are not required to participate in a company training program.

An approved insurance company training program must include instruction in Oklahoma statutes and regulations. Training received as part of the licensing process in Oklahoma satisfies this requirement in part.

CONTACT PERSON:

Karl F. Kramer, First Assistant General Counsel, (405) 521-2746

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S. SECTION 253(D), WITH A LATER EFFECTIVE DATE OF NOVEMBER 1, 2007:

SUBCHAPTER 3. PRODUCERS, BROKERS AND LIMITED LINES PRODUCERS

365:25-3-1. Insurance producers continuing education

(a) **Purpose.** The purpose of this section is to set forth the requirements for continuing education, which an insurance producer must meet and to set forth the requirements for approval by the Insurance Commissioner of a proposed continuing education course.

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

- (1) **"CEC"** means continuing education credit.
- (2) **"Certificate of course completion"** means a document acceptable to the Commissioner which signifies satisfactory completion of the course and reflects hours of credit earned.
- (3) **"Continuing Education Advisory Committee"** means the committee established by the Commissioner for the purpose of reviewing and recommending approval or disapproval of continuing education courses.
- (4) **"Credit hour"** means at least a fifty (50) minutes classroom instruction unless a correspondence or self-study course.
- (5) **"Instructor"** means a person who presents course materials approved for continuing education credit hours, and who has experience, training, and/or education in

the course subject matter and has been approved by the Commissioner.

(6) **"Instructor Qualification Form"** means a form acceptable to the Commissioner and completed by the instructor which documents qualifications of the instructor.

(7) **"Licensee"** means a natural person who is licensed by the Commissioner as an insurance producer.

(8) **"Provider"** means a person, corporation, professional association or its local affiliates, an insurance company or any other entity which is approved by the Commissioner and provides approved continuing education to insurance producers.

(9) **"Provider Course Completion Form"** means a form acceptable to the Commissioner and completed by the provider which documents completion of an approved course by a producer or producers.

(c) **Exceptions.** The requirements for continuing education in this section shall not apply to:

- (1) limited lines producers.
- (2) a non-resident producer who resides and is licensed in a state or district having continuing education requirements and the producer meets all the requirements of that state or district to practice therein. The non-resident producer shall be responsible for completing any reporting requirements necessary to verify completion.
- (3) a non-resident producer of a state that does not require continuing education hours may fulfill the requirements of any other state's continuing education requirements and shall be deemed to have complied with this rule upon proof of completion of said hours.

(d) **Continuing education requirements.**

(1) **CEC during twenty-four month period.** All licensees shall complete the required hours of continuing education as set forth in 36 O.S. § 1435.29 during each twenty-four month period. The twenty-four month period begins the first day of the month following the month in which the license is granted. The credit hours completed must be in those lines in which the producer is licensed. Ethics shall include, but not be limited to, the study of fiduciary responsibility, commingling of funds, payment and acceptance of commissions, unfair claims practices, policy replacement consideration, and conflicts of interest.

(2) **Certificates of course completion required for license renewal.** If requested by the Insurance Department, each producer shall submit upon each licensing renewal certificate(s) of course completion as approved by the Insurance Department, which verify courses completed during the previous twenty-four month period.

(3) **Credits carried over.** Credit hours in excess of the minimum twenty-four month period requirement will not carry forward. However, excess hours may be applied to bring a lapsed license into compliance.

(4) **Elective Credit.** At least two (2) of the continuing education credit hours of instruction completed by licensees each twenty-four month period shall be taken in the following topics:

- (A) state legislative updates
- (B) federal legislative updates

Emergency Adoptions

- (C) health coverage
- (D) welfare coverage
- (5) **Credits for instructors.** An instructor who is a licensee shall receive the same continuing education credit for presenting approved course materials as a licensee who attends an approved classroom instructional session.
- (6) **Prerequisite for renewal or reinstatement.** As a prerequisite for licensure renewal or upon reinstatement following a lapse of license, a producer must submit, on his or her renewal/reinstatement date, the appropriate forms as specified in this section which establish that the education requirements have been met for the previous year(s).
- (e) **Approval of continuing education providers.**
 - (1) **Information required, fee.** Each provider shall apply for approval from the Commissioner. Each provider, with the exception of public funded educational institutions, federal agencies or Oklahoma state agencies shall submit after its approval a provider fee of Two Hundred Dollars (\$200.00), and all providers, including public funded educational institutions, federal agencies and Oklahoma agencies shall provide:
 - (A) Name and address of the provider;
 - (B) Contact person and his or her address and telephone number;
 - (C) The location of the courses or programs, if known, unless it is an individual self-study course;
 - (D) The number of CEC hours requested for each course;
 - (E) Topic outlines which list the summarized topics covered in each course and a copy of any course materials. If a prior approved course has substantially changed, a summarization of those changes;
 - (F) The names and qualification of instructors. An instructor shall have one of the following qualifications:
 - (i) Three (3) years of recent experience in the subject area being taught; or
 - (ii) A degree related to the subject area being taught; or
 - (iii) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.
 - (G) If a prior approved course has materially changed, a summarization of those changes;
 - (2) **Renewal fee.** An annual renewal fee of Two Hundred Dollars (\$200.00) shall be payable on or before the approval anniversary date of each year by each provider to renew the approval of the provider. A fee of double the annual renewal fee shall be paid if the application for renewal is late, or incomplete on the approval anniversary date.
 - (3) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval of any provider for violation of or non-compliance with any provision of this section.
- (f) **Courses; approval; records.**
 - (1) **Timeline for approval.** At least thirty (30) days prior to the use of any course and not less than ten (10) days prior to the Continuing Education Advisory Committee meeting immediately preceding the course date, the provider shall apply to the Commissioner for course approval. The Commissioner shall grant or deny approval based upon information submitted in this section regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of CEC hours awarded for an approved course and the line or lines of insurance for which the course qualifies.
 - (2) **Written approval required.** All courses shall require written approval by the Commissioner. Courses shall be deemed to have been approved by the Commissioner if the courses are provided by national professional associations or local affiliates of national professional associations approved by the Commissioner to act as providers of continuing education.
 - (3) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval for any course approval. This withdrawal will not affect any CEC hours attained under the course previous to the withdrawal.
 - (4) **Minimum of one credit hour.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.
 - (5) **Continuing education course must be separate from meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.
 - (6) **Content of courses.** Courses must be of a meaningful nature and shall not include items such as prospecting, motivation, sales techniques, psychology, recruiting, and subjects not relating to the insurance license. However, agency management courses designed to assist producers in becoming more efficient, profitable, and assuring their perpetuation, will be deemed to be in the best interest of the insuring public and thereby subject to approval. Each such agency management course must include the description, the effects the course is designed to accomplish toward the purposes of efficiency, profitability, and/or perpetuation and each course will be reviewed for approval on its own merits.
 - (7) **Certificate of Course Completion.** At the completion of each course, the provider shall provide the insurance producer a "Certificate of Course Completion" Form.
 - (8) **List of producers completing course to Commissioner; producer license numbers.** Within ten (10) business days after completion of each course, the provider shall provide the Commissioner a list of all insurance producers who completed the course on the Course Completion Form. This list shall contain the course number, date of completion and license numbers of all insurance producers completing the course. If the list is not reported within ten (10) business days, a late report fee of \$50.00 shall be paid to the Insurance Department. Failure to pay the late report fee may result in revocation

of provider approval. Continued late filing may also result in loss of approval.

(9) **Course records maintained four years.** Providers shall maintain course records for at least four (4) years. The Commissioner may order an examination of a provider, at the provider's expense, for good cause shown.

(10) **Repeated approved course.** At least fourteen (14) days prior to the repetition of an approved course, the Commissioner shall be notified in writing of the repetition, providing course number, name, date and instructor's name.

(11) **Course evaluation.** The provider shall require each producer listed on the Course Completion Form to complete a course evaluation form to be submitted to the Department within ten (10) business days after completion of each course.

(g) **Approved Professional Designation Programs**

(1) **Definitions.**

(A) **Participation.** As used in 36 O.S. § 1435.29(B)(3), participates means successfully completing any part of a course curriculum totaling twenty (20) classroom or equivalent classroom hours of an approved professional designation program.

(B) **Approved Professional Designation Program.** As used in 36 O.S. § 1435.29 (B)(3), an approved professional designation program means an educational insurance program approved by the Commissioner with a sponsoring organization that administers curriculum requirements and testing standards for candidates.

(2) **Requirements.** A professional designation program shall satisfy the following criteria to receive initial and ongoing approval for the program:

(A) The program shall have a sponsoring organization;

(B) The program's sponsoring organization shall maintain and govern a code of conduct;

(C) The program shall be relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma;

(D) Each course of the professional designation course curriculum shall be a minimum of twenty (20) hours classroom instruction or equivalent classroom instruction;

(E) The program shall have an examination requirement that students shall pass before earning the designation.

(3) **Submissions.** The sponsoring organization shall submit the following to the Commissioner for its professional designation program to be considered for initial and ongoing approval for the program:

(A) The sponsoring organization's code of conduct;

(B) The sponsoring organization's membership requirements;

(C) The professional designation program's course requirements; and

(D) The professional designation program's examination requirements;

(4) **Submission exemptions.** Professional designation programs recognized by the National Association of Insurance Commissioners (NAIC) for waiver/exemption of pre-licensing education training shall receive initial and continuing approval without submission by the sponsoring organization.

(h) **Presumptive Continuing Education Approval.**

(1) **Requirements.** Professional associations may receive presumptive approval of their continuing education courses by satisfying the following requirements:

(A) The association shall have a mission statement that includes a commitment to enhance the professional, educational, or ethical skills of its members;

(B) The association shall maintain and govern a code of member conduct;

(C) The association shall offer educational programs relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma;

(D) The association shall perpetuate its continuity through the election of officers.

(2) **Submissions.** Each professional association shall submit the following to be considered for initial and ongoing presumptive course approval:

(A) The association's mission statement;

(B) The association's code of member conduct;

(C) The chapter officers, the responsibilities for each officer, and the term of office for each officer;

(D) The mailing address and primary contact for the association; and

(E) The list of continuing education courses approved in Oklahoma and offered by the professional association in the past twenty-four (24) months.

(3) **Notification of approval or disapproval.** The Commissioner shall notify the association whether all or a part of its continuing education courses receive presumptive approval within ninety (90) days from receipt of a submission. The Commissioner shall send written notification to the association via certified mail, return receipt requested if all or part of a course submission is disallowed. The notification shall also indicate the reasons for disapproval.

(4) **Assignment of course number.** The association shall submit to the Commissioner a brief statement of content, instructor name, course date and location within five (5) business days of the presentation for assignment of course number.

(5) **Instructor approval.** Instructors shall be approved by the Commissioner five (5) days prior to a presentation. The Commissioner may disapprove any course if instructor approval has not been granted.

(6) **Review.** Course approval shall be reviewed every three (3) years. The association shall re-submit the items required in subparagraph two (2) during the fourth quarter of the last approval year.

(7) **Agency Management Courses.** Agency management courses shall not be considered for presumptive continuing education approval.

Emergency Adoptions

(g*j*) **Self study and Distance Learning Courses.** The Insurance Commissioner shall determine appropriate guidelines and standards for self-study and distance learning CEC offerings. The guidelines and standards shall include authentication of the registered licensee, technology requirements for course delivery and testing protocols. Guidelines and standards shall be reviewed, updated as appropriate, and published annually. Failure to follow the guidelines and standards established by the Commissioner may result in denial of continuing education credit for the producer and revocation of the course approval and or provider status for the provider.

(h*j*) **Repeating courses.** An insurance producer may repeat a course within the twenty-four month period if the maximum credits designated for the course were not attained in the first attempt. By repeating the course, the producer may not during the twenty-four month period earn more than the maximum credits designated for the course. A producer may repeat a course after two years have elapsed and receive the maximum credits designated for the course. This section shall not apply to ethics courses.

(i*k*) **Extension of time.** For good cause shown, the Commissioner may grant an extension of time during which the requirements imposed by the act may be completed. The extension shall not exceed twelve (12) months. The extension will not alter the requirements or due date of the succeeding twenty-four-month period. "Good cause" includes disability, natural disaster, or other extenuating circumstances. Each request for extension of time shall be in writing from the licensee and shall include details and any documentation to support the request. Each request must be received by the Commissioner no less than thirty (30) days before the expiration of the twenty-four month period.

(j*l*) **Course approval.** Prior to the Commissioner's approval or disapproval of a course in 365:25-3-1(f), a continuing education advisory committee will review the course submitted and make its nonbinding recommendation to the Commissioner on granting or denying approval based upon information submitted in 365:25-3-1(e) regarding the course or additional information regarding the course, if necessary, the number of CEC hours awarded for an approved course and the line or lines of insurance for which the course qualifies. Each course approval shall be valid for a period of not more than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course approval following the review of material changes shall reset the validity period. At the expiration of the validity period, providers shall submit the course for approval by the Commissioner if the provider wants to continue to offer the course for continuing education credit.

(k*m*) **Severability provision.** If any provision of this section, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the section, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

365:25-3-1.1. Application for Resident Producer License

(a) **Requirements.** An applicant for a resident insurance producer license shall either hold a provisional producer license and complete eight (8) hours of pre-licensing education required by 36 O.S. § 1435.7A(B)(4) or participate in an approved insurance company training program.

(b) **Exceptions.** A provisional producer license or participation in an approved insurance company training program is not required for the following producer license applicants:

(1) Limited lines producer;

(2) Surplus lines insurance broker;

(3) A title insurance producer licensed prior to November 1, 2006, who is an applicant for an aircraft title producer license;

(4) A person licensed as an insurance producer in another state who moves to this state and makes application to become a resident licensee within ninety (90) days of establishing legal residence in Oklahoma; and

(5) A person reinstating a lapsed license within twenty-four (24) months from the due date of the renewal fee.

365:25-3-1.2. Provisional Producer Licensees

(a) **Sponsoring producers.** A sponsoring producer may supervise no more than five (5) provisional licensees at any time.

(b) **Pre-licensing education.** The Commissioner shall develop and publish the topic outlines covered in the eight (8) hours of pre-licensing education. Providers and course submissions shall be approved by the Commissioner in the same manner as applicable to continuing education courses. Course submission shall include all course materials. All courses shall be offered as classroom instruction.

(c) **Time requirements-exceptions.** A provisional producer license may be held for up to six (6) months to complete pre-licensing education requirements. A licensee who is unable to comply with pre-licensing education requirements due to military service, a medical condition, or other extenuating circumstance may request an extension of time to complete the requirements. The request shall be in writing.

365:25-3-1.3. Approved Insurance Company Training Program

(a) **Requirements.** An insurance company shall certify on the affidavit required by Appendix T of this chapter that its training program satisfies all criteria required by the affidavit.

(b) **Notification.** An insurance company shall notify the Commissioner within thirty (30) days if changes to its training program do not fulfill the requirements set forth in the affidavit.

(c) **Participation.** A producer shall document participation by completing a form provided by the Commissioner. The form shall be submitted with the producer application.

365:25-3-14. Insurance adjusters continuing education

(a) **Purpose.** The purpose of this section is to set forth the requirements for continuing education which an insurance adjuster must meet, and to set forth the requirements for approval

by the Insurance Commissioner of a proposed continuing education course.

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

- (1) **"CEC"** means continuing education credit.
- (2) **"Certificate of course completion"** means a document acceptable to the Commissioner which signifies satisfactory completion of the course and reflects hours of credit earned.
- (3) **"Continuing Education Advisory Committee"** means the committee established by the Commissioner for the purpose of reviewing and recommending approval or disapproval of continuing education courses.
- (4) **"Credit hour"** means at least fifty (50) minutes of classroom instruction unless a correspondence or self-study course.
- (5) **"Instructor"** means a person who presents course materials approved for continuing education credit hours, and who has experience, training, and/or education in the course subject matter and has been approved by the Commissioner.
- (6) **"Instructor Qualification Form"** means a form acceptable to the Commissioner and completed by the instructor which documents qualifications of the instructor.
- (7) **"Licensee"** means a natural person who is licensed by the Commissioner as an insurance adjuster.
- (8) **"Provider"** means a person, corporation, professional association or its local affiliates, an insurance company or any other entity which is approved by the Commissioner and provides approved continuing education to insurance adjusters.
- (9) **"Provider Course Completion Form"** means a form acceptable to the Commissioner and completed by the provider which documents completion of an approved course by an adjuster or adjusters.

(c) **Exceptions.** The requirements for continuing education in this section shall not apply to:

- (1) a non-resident adjuster who resides and is licensed in a state or district having continuing education requirements and the adjuster meets all the requirements of that state or district to practice therein. The non-resident adjuster shall be responsible for completing any reporting requirements necessary to verify completion.
- (2) a non-resident adjuster of a state that does not require continuing education hours may fulfill the continuing education requirements of any other state in which the individual is licensed and shall be deemed to have complied with this rule upon proof of completion of said hours.

(d) **Continuing education requirements.**

- (1) **Twelve hours of CEC during twenty-four month period.** All licensees shall complete twelve (12) credit hours of continuing education during each twenty-four month period. The twenty-four month period begins the first day of the month following the month in which the license is granted. The credit hours completed must be in those lines in which the adjuster is licensed. Courses

taken in excess of twelve (12) hours will not carry forward. However, courses taken in excess of twelve (12) hours may be applied retroactively in order to bring a lapsed license into compliance.

(2) **Certificates of course completion required for license renewal.** If course completion is not reflected on the license renewal form issued by the Insurance Department, each adjuster shall attach, if requested by the Commissioner, an approved course completion certificate to the license renewal form returned to the Department for verification of course completion. The Commissioner shall maintain a cumulative total of continuing education credit hours to insure compliance within the twenty-four (24) month period.

(3) **Credits for instructors.** An instructor who is a licensee shall receive the same continuing education credit for presenting approved course materials as a licensee who attends an approved classroom instructional session by including his/her name and license number on roster.

(4) **Prerequisite for renewal or reinstatement.** As a prerequisite for license renewal or prior to reinstatement following a lapse of license, an adjuster must submit the appropriate forms as specified in this section that establish the educational requirements have been met if not currently recorded by the Oklahoma Insurance Department.

(e) **Approval of continuing education providers.**

(1) **Information required.** Each provider shall apply for approval by the Commissioner. All providers, including publicly funded educational institutions, federal agencies, or Oklahoma state agencies, shall provide:

- (A) Name and address of the provider.
- (B) Contact person and his or her address and telephone number(s).
- (C) The location of the courses or programs, if known, unless it is an individual self-study course.
- (D) The number of CEC hours requested for each course.
- (E) Topic outlines which list the summarized topics covered in each course and a copy of any course materials.
- (F) The names and qualification of instructors. An instructor shall have one of the following qualifications:

- (i) Three (3) years of recent experience in the subject area being taught; or
- (ii) A degree related to the subject area being taught; or
- (iii) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.

(G) If a prior approved course has materially changed, a summarization of those changes.

(2) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval of any provider for violation of or non-compliance with any provision of this section.

(f) **Courses; approval; records.**

Emergency Adoptions

- (1) **Course approval timeline.** A provider shall apply to the Commissioner for course approval by submitting forms and materials to the Commissioner the first day of the month one full month prior to the date of the first course offering. The Commissioner shall grant or deny approval based upon information submitted in this section regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of CEC hours awarded for an approved course and the line or lines of insurance for which the course qualifies.
 - (2) **Repeated approved course.** At least fourteen (14) days prior to the repetition of an approved course, the Commissioner shall be notified in writing of the repetition, providing course number, name, date, location and instructor's name.
 - (3) **Written approval required.** All courses shall require written approval.
 - (4) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval for any course. This withdrawal will not affect any CEC hours attained under the course previous to the withdrawal.
 - (5) **Minimum of one credit hour.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.
 - (6) **Continuing education course must be separate from meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.
 - (7) **Content of courses.** Courses must be of a meaningful nature and shall not include items such as prospecting, motivation, sales techniques, psychology, recruiting, time management, phone etiquette, basic pre-licensing principles of adjusting, and subjects not relating to the adjuster's license.
 - (8) **Certificate of Course Completion.** At the completion of each course, the provider shall provide the insurance adjuster a "Certificate of Course Completion" Form.
 - (9) **List of adjusters completing course to Commissioner.** Within ten (10) business days after completion of each course, the provider shall provide the Commissioner a list of all insurance adjusters who completed the course on the Course Completion Form. This list shall contain the course number, date of completion and license numbers of all insurance adjusters completing the course. If the list is not reported within ten (10) business days, a late report fee of \$50.00 shall be paid to the Insurance Department. Failure to pay the late report fee may result in revocation of provider approval. Continued late filing may also result in loss of approval.
 - (10) **Course records maintained four (4) years.** Providers shall maintain course records for at least four (4) years. The Commissioner may order an examination of a provider, at the provider's expense, for good cause shown.
- (g) **Approved Professional Designation Programs**
- (1) **Definitions.**
 - (A) **Participation.** As used in 36 O.S. § 6217(C), participates means successfully completing any part of a course curriculum totaling twenty (20) classroom or equivalent classroom hours of an approved professional designation program.
 - (B) **Approved Professional Designation Program.** As used in 36 O.S. § 6217(C), an approved professional designation program means an educational insurance program approved by the Commissioner with a sponsoring organization that administers curriculum requirements and testing standards for candidates.
 - (2) **Requirements.** A professional designation program shall satisfy the following criteria to receive initial and ongoing approval for the program:
 - (A) The program shall have a sponsoring organization;
 - (B) The program's sponsoring organization shall maintain and govern a code of conduct;
 - (C) The program shall be relevant to the sale, solicitation, or negotiation of insurance products or claims adjusting in the State of Oklahoma;
 - (D) Each course of the professional designation course curriculum shall be a minimum of twenty (20) hours classroom instruction or equivalent classroom instruction; and
 - (E) The program shall have an examination requirement that students shall pass before earning the designation.
 - (3) **Submissions.** The sponsoring organization shall submit the following to the Commissioner for its professional designation program to be considered for initial and ongoing approval for the program:
 - (A) The sponsoring organization's code of conduct;
 - (B) The sponsoring organization's membership requirements;
 - (C) The professional designation program's course requirements; and
 - (D) The professional designation program's examination requirements.
 - (4) **Submission exemptions.** Professional designation programs recognized by the National Association of Insurance Commissioners (NAIC) for waiver/exemption of pre-licensing education training shall receive initial and continuing approval without submission by the sponsoring organization.
- (h) **Presumptive Continuing Education Approval.**
- (1) **Requirements.** Professional associations may receive presumptive approval of their continuing education courses by satisfying the following requirements:
 - (A) The association shall have a mission statement that includes a commitment to enhance the professional, educational, or ethical skills of its members;
 - (B) The association shall maintain and govern a code of member conduct;
 - (C) The association shall offer educational programs relevant to the sale, solicitation, negotiation of

insurance products or claims adjusting in the State of Oklahoma; and

(D) The association shall perpetuate its continuity through the election of officers.

(2) Submissions. Each professional association shall submit the following to be considered for initial and on-going presumptive course approval:

(A) The association's mission statement;

(B) The association's code of member conduct;

(C) The chapter officers, the responsibilities for each officer, and the term of office for each officer;

(D) The mailing address and primary contact for the association; and

(E) The list of continuing education courses approved in Oklahoma and offered by the professional association in the past twenty-four (24) months.

(3) Notification of approval or disapproval. The Commissioner shall notify the association whether all or a part of its continuing education courses have received presumptive approval within ninety (90) days from receipt of a submission. The Commissioner shall send written notification to the association via certified mail return receipt requested if all or part of a course submission is disallowed. The notification shall also indicate the reasons for disapproval.

(4) Assignment of course number. The association shall submit to the Commissioner a brief statement of content, instructor name, course date and location with five (5) business days of the presentation for assignment of course number.

(5) Instructor approval. Instructors shall be approved by the Commissioner five (5) days prior to a presentation. The Commissioner may disapprove any course if instructor approval has not been granted.

(6) Review. Course approval shall be reviewed every three (3) years. The association shall re-submit the items required in subparagraph two (2) during the fourth quarter of the last approval year.

(7) Agency Management Courses. Agency management courses shall not be considered for presumptive continuing education approval.

(g.i) Self study and distance learning courses. The Insurance Commissioner shall determine appropriate guidelines and standards for self-study and distance learning CEC offerings. The guidelines and standards shall include authentication of the registered licensee, technology requirements for course delivery and testing protocols. Guidelines and standards shall be reviewed and updated as appropriate and published on the Commissioner's website annually. Failure to follow the guidelines and standards established by the Commissioner may result in denial of continuing education credit for the adjuster and revocation of the course approval and or provider status for the Provider.

(h.j) Repeating courses. An insurance adjuster may repeat a course within the twenty-four month period if the maximum credits designated for the course were not attained in the first

attempt. By repeating the course, the adjuster may not during the twelve month period earn more than the maximum credits designated for the course. An adjuster may repeat a course after two (2) license renewal dates have elapsed and receive the maximum credits designated for the course.

(i.k) Extension of time. For good cause shown, the Commissioner may grant an extension of time during which the requirements imposed by the act may be completed. The extension shall not exceed twelve (12) months. The extension will not alter the requirements or due date of the succeeding twelve-month period. "Good cause" includes disability, natural disaster, or other extenuating circumstances. Each request for extension of time shall be in writing from the licensee and shall include details and any documentation to support the request. Each request must be received by the Commissioner no less than thirty (30) days before the expiration of the twenty-four month period.

(j.l) Continuing education advisory committee.

(1) There shall hereby be established the Continuing Education Advisory Committee. This committee shall consist of representatives from the Agents Licensing Division, and representatives from the industry (not to exceed three (3) individuals) as designated by the Commissioner. Members of the Advisory Board established by 36 O.S. § 6221 may also serve on the Continuing Education Advisory Committee. The committee shall meet at least quarterly and additionally as required. Members of the committee shall serve without pay and shall not be reimbursed for any expenses associated therewith.

(2) Prior to the Commissioner's approval or disapproval of a course in 365:25-3-14(e), the Continuing Education Advisory Committee will review the course submitted and make its nonbinding recommendation to the Commissioner on granting or denying approval based upon information submitted pursuant to 365:25-3-14(e) and additional information regarding the course, if necessary. Each course approval shall be valid for a period of no longer than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course materials may be resubmitted as requested for review at the time of expiration. All existing courses previously approved and current with the Commissioner shall be submitted in accordance with the expiration date as granted by the Commissioner unless the course has a material change, as previously detailed.

(k.m) Severability provision. If any provision of this section, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the section, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

[OAR Docket #07-1417; filed 10-9-07]

Executive Orders

As required by 75 O.S., Sections 255 and 256, Executive Orders issued by the Governor of Oklahoma are published in both the *Oklahoma Register* and the *Oklahoma Administrative Code*. Executive Orders are codified in Title 1 of the *Oklahoma Administrative Code*.

Pursuant to 75 O.S., Section 256(B)(3), "Executive Orders of previous gubernatorial administrations shall terminate ninety (90) calendar days following the inauguration of the next Governor unless otherwise terminated or continued during that time by Executive Order."

TITLE 1. EXECUTIVE ORDERS

1:2007-40.

EXECUTIVE ORDER 2007-40

I, Brad Henry, Governor of the State of Oklahoma, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. until 5:00 p.m. on Wednesday, October 3, 2007, to honor Staff Sergeant Kevin R. Brown, an Oklahoma resident, who died on Tuesday September 25 at age 38. He was killed while serving in Iraq.

This executive order shall be forwarded to the Director of Central Services who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 2nd day of October, 2007.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State

[OAR Docket #07-1415; filed 10-3-07]
